

Print Clearly

APPLICATION

Silver Spring Ambulance and Rescue Association, Inc. April 1, 2008 – March 31, 2009 Subscription Application Form

The Silver Spring Ambulance & Rescue Association, Inc. will seek any available third party benefits.

HEAD OF HOUSEHOLD: _____ SUBSCRIPTION: \$ _____
 ADDRESS: _____ Household \$70
 CITY: _____ STATE: _____ ZIP: _____ DONATION: \$ _____
 PHONE: _____ TOTAL ENCLOSED: \$ _____
 All persons to be covered by Subscriptions: CHECK NUMBER: _____

Name	Birth Date
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

I authorize that payment of qualified Medicare benefits or other insurance benefits be made on my behalf for any services furnished by Silver Spring Ambulance and West Shore ALS. I also authorize any holder of medical information or documentation about me to release that information to the Health Care Financing Administration and its carrier and agents, as well as these health service providers, and any information or documentation needed to determine these benefits or benefits payable for services provided to me by these health service providers now or in the future.

SIGNATURE X (SIGN): _____ DATE: _____
(HEAD OF HOUSEHOLD)

RETURN THIS COMPLETED FORM WITH YOUR PAYMENT

MAKE CHECK PAYABLE TO:
SILVER SPRING AMBULANCE AND RESCUE ASSOCIATION, INC.

Detach here and return top portion to:

Silver Spring Ambulance and Rescue Association, Inc.
Po Box 177
New Kingstown, Pa 17072-0177

RECEIPT

2008-2009 Subscriber Card

Check Number: _____
Amount: _____

**AN IMPORTANT MESSAGE FROM YOUR AMBULANCE SERVICE SUBSCRIPTION BASIC FUNDING
FOR YOUR AMBULANCE SERVICE**

Silver Spring Ambulance and Rescue Association, Inc. depends upon your support to provide the high standard emergency medical services you deserve. With your contribution, we can continue to equip our ambulances with the best available equipment.