Enosburgh Ambulance Service

PO Box 465 • Enosburg Falls, VT 05450 • Phone (802) 933-2118

Annual Subscription

Membership:

The cost is $100 per household/Per Year. Membership fee provides local emergency medical ambulance service to you and anyone living in your household as medically needed in the Enosburgh Ambulance 911 response area.

The principal subscriber and ***all persons living in the household*** residing in our normal call area will be covered under this membership.

Enosburgh Ambulance Service reserves the right to bill any available third-party insurance agency. Additional donations are tax deductible.

Business Membership:

The cost is $100 per business and $5 per employee. (Please list employees on a separate sheet)

Enosburgh Ambulance Subscription Application

☐ New ☐ Renewal

Office use only

Date Entered: _____

(Please Print)

Subscriber _____

Mailing Address _____ Apt # _____

City _____ State _____ Zip _____ Phone _____

List Current Dependents

_____

_____

_____

_____

PLEASE READ AND SIGN THE AGREEMENT BELOW

I hereby apply for Enosburgh Ambulance Service membership for myself, and my dependents listed.

I understand that the $100 per family per year membership fee provides local emergency medical ambulance service to me and everyone living in the household as medically needed in the Enosburgh Ambulance 911 response area. The membership fee will cover any applicable deductible or co-payments. I understand that this membership permits Enosburgh Ambulance Service to collect directly from any third-party agency whatever benefits may be available at no charge to me or my family, and that this membership is nonrefundable and is nontransferable. I request payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to Enosburgh Ambulance Service, for any ambulance services and supplies furnished to me by Enosburgh Ambulance Service whether in the past, present or in the future. I authorize any holder of medical information about me or other relevant documentation about me to be released to Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third-party payers, whether in the past, present or in the future.

Signature: _____ **Date:** _____

Please send application and check to: Enosburgh Ambulance Service, PO Box 465, Enosburg Falls, VT 05450