



City of South Pasadena PARAMEDIC SUBSCRIPTION PROGRAM

Name of Subscriber or Business: _____

Address: _____

Phone Number: _____

Please list yourself and all the members of the household who will be covered under your membership (Must be living at your home on a regular basis)

Name: _____ SS#: _____ D.O.B.: _____
(Yourself) (Optional)

ID/Member #: _____

Insurance Company: _____ Group #: _____

Do you have Medicare: Y N If yes, MBI # _____

Name: _____ SS#: _____ D.O.B.: _____
(Optional)

ID/Member #: _____

Insurance Company: _____ Group #: _____

Do you have Medicare: Y N If yes, MBI # _____

Name: _____ SS#: _____ D.O.B.: _____
(Optional)

ID/Member #: _____

Insurance Company: _____ Group #: _____

Do you have Medicare: Y N If yes, MBI # _____

Name: _____ SS#: _____ D.O.B.: _____

(Optional)

ID/Member #: _____

Insurance Company: _____ Group #: _____

Do you have Medicare: Y N If yes, MBI # _____

Name: _____ SS#: _____ D.O.B.: _____

(Optional)

ID/Member #: _____

Insurance Company: _____ Group #: _____

Do you have Medicare: Y N If yes, MBI # _____

For Businesses Only

(\$90.00 per year for the first 10 employees plus \$20.00 for each additional 10 employees)

Number of Employees: _____ Official Contact: _____

Contact Number: _____

Read the statement carefully and sign and date application

I hereby apply for membership for myself and listed members of my immediate family who live at my residential address, or a business within the City of South Pasadena and I declare that I am a resident or the business is of the City of South Pasadena. I understand that the annual fee of **\$80.00** for a household, or **\$90.00** for a business, less than 10 persons will provides prehospital emergency medical care and ambulance transportation, as often as needed, by the City of South Pasadena. This service will be provided free of charge for one year ending December 31. I also understand that coverage is in excess of any insurance or medical benefits, which I may have, and I authorize the release of medical information for the purpose of ambulance insurance billing only. Should a family member or I receive payment by insurance or medical benefits provides for ambulance service rendered, I will immediately forward such payment to the City of South Pasadena. I understand that my membership covers all unpaid balances and that will not be billed. This membership is nonrefundable and nontransferable. This service is between the subscriber and the City of South Pasadena only and DOES NOT cover charges or fees from other Fire Department's or Private Ambulance Companies.

I HAVE READ THE ABOVE AGREEMENT AND UNDERSTAND THE TERMS

Signature _____ Date _____

Additional Members:

Name: _____ SS#: _____ D.O.B.: _____
(Optional)
ID/Member #: _____
Insurance Company: _____ Group #: _____
Do you have Medicare: Y N If yes, MBI # _____

Name: _____ SS#: _____ D.O.B.: _____
(Optional)
ID/Member #: _____
Insurance Company: _____ Group #: _____
Do you have Medicare: Y N If yes, MBI # _____

Name: _____ SS#: _____ D.O.B.: _____
(Optional)
ID/Member #: _____
Insurance Company: _____ Group #: _____
Do you have Medicare: Y N If yes, MBI # _____

Name: _____ SS#: _____ D.O.B.: _____
(Optional)
ID/Member #: _____
Insurance Company: _____ Group #: _____
Do you have Medicare: Y N If yes, MBI # _____

Name: _____ SS#: _____ D.O.B.: _____
(Optional)
ID/Member #: _____
Insurance Company: _____ Group #: _____
Do you have Medicare: Y N If yes, MBI # _____