



Longview Fire-Rescue Department



MEMBERSHIP APPLICATION

PLEASE COMPLETE AND SIGN BELOW EVEN IF YOU HAVE NO CHANGES TO YOUR CURRENT MEMBERSHIP. INCOMPLETE OR UNSIGNED APPLICATIONS WILL NOT BE APPROVED

APPLICANT

LAST NAME		FIRST NAME		MIDDLE INITIAL	<input type="checkbox"/> M <input type="checkbox"/> F
STREET ADDRESS		CITY, STATE, ZIP		PHONE NUMBER ()	
DATE OF BIRTH		SOCIAL SECURITY #		ALTERNATE PHONE NUMBER ()	
PRIMARY INSURANCE COMPANY OR MEDICARE INFORMATION					
INSURANCE NAME		POLICY #	GROUP #	PHONE # ()	
CLAIMS MAILING ADDRESS		CITY	STATE	ZIP CODE	
SECONDARY INSURANCE INFORMATION					
INSURANCE NAME		POLICY #	GROUP #	PHONE # ()	
CLAIMS MAILING ADDRESS		CITY	STATE	ZIP CODE	

SPOUSE OR DEPENDENT

LAST NAME		FIRST NAME		MIDDLE INITIAL	<input type="checkbox"/> M <input type="checkbox"/> F
STREET ADDRESS		CITY, STATE, ZIP		PHONE NUMBER ()	
DATE OF BIRTH		SOCIAL SECURITY #		ALTERNATE PHONE NUMBER ()	
PRIMARY INSURANCE COMPANY OR MEDICARE INFORMATION					
INSURANCE NAME		POLICY #	GROUP #	PHONE # ()	
CLAIMS MAILING ADDRESS		CITY	STATE	ZIP CODE	
SECONDARY INSURANCE INFORMATION					
INSURANCE NAME		POLICY #	GROUP #	PHONE # ()	
CLAIMS MAILING ADDRESS		CITY	STATE	ZIP CODE	

DEPENDENT

LAST NAME		FIRST NAME		MIDDLE INITIAL	<input type="checkbox"/> M <input type="checkbox"/> F
STREET ADDRESS		CITY, STATE, ZIP		PHONE NUMBER ()	
DATE OF BIRTH		SOCIAL SECURITY #		ALTERNATE PHONE NUMBER ()	
PRIMARY INSURANCE COMPANY OR MEDICARE INFORMATION					
INSURANCE NAME		POLICY #	GROUP #	PHONE # ()	
CLAIMS MAILING ADDRESS		CITY	STATE	ZIP CODE	
SECONDARY INSURANCE INFORMATION					
INSURANCE NAME		POLICY #	GROUP #	PHONE # ()	
CLAIMS MAILING ADDRESS		CITY	STATE	ZIP CODE	

For additional family members please use back of application.

Please return this application with your check, money order or credit card information to the address below.

City of Longview Fire-Rescue Department

PO BOX 1952

Longview, Texas 75606

Credit Card Payments: Visa Master Card Discover

Card Number: _____ Expiration Date: _____ Vcode: _ _ _

Signature: _____ Date: _____

AMBULANCE SUBSCRIPTION MEMBERSHIP AGREEMENT
THIS IS NOT AN INSURANCE POLICY

The undersigned applicant(s) hereby apply for membership with the City of Longview Fire –Rescue Department Ambulance Subscription Service Membership (hereinafter referred to as the “Membership”). Only persons residing within the corporate limits of the City of Longview, Texas, are eligible to participate in this Membership. I understand that the enclosed annual fee of \$70.00 will cover myself, my spouse, unmarried dependent children under 25 years of age and other persons living at this address who qualify as my dependents for purposes of federal income tax. The subscription period for a Membership is from January 1 of each year through December 31 of that calendar year. THIS MEMBERSHIP IS NON-REFUNDABLE AND NON-TRANSFERABLE. I understand that through this Membership, the Longview Fire-Rescue Department will provide **EMERGENCY** ambulance service solely within the city limits of Longview, Texas, only when the destination is one of our local hospitals. I give my permission for the Longview Fire-Rescue Department to bill my insurance and to obtain benefits to which I or persons providing services to me are entitled through my insurance carriers. This membership will cover the portion unreimbursed by my medical coverage for services rendered by Longview Fire-Rescue Department during the time of my membership. If the transported person does not have health care insurance, this Membership covers emergency medical services delivered prior to hospital arrival.

I authorize the release of medical information for the purpose of billing my insurance. I understand that should I or any other person covered by this Membership receive payment from insurance or any other medical provider for services rendered by Longview Fire-Rescue Department, the payment must be immediately forwarded to Longview Fire-Rescue Department to the extent necessary to satisfy any balance due.

I understand that Medicaid recipients may not participate in this program. I understand and agree that the emergency medical services to be provided under this agreement are a governmental service. I also understand and agree that the city’s liability and the liability of the city’s employees and officials are governed solely by the Texas Tort Claims Act (Chapter 101 of the Texas Civil Practice and Remedies Code). This agreement does not constitute a waiver or modification of such law.

I understand the Longview Fire-Rescue Department provides ambulance transportation in emergency cases only and not for transfer ambulance service. Violations of the terms of this agreement may result in immediate cancellation of my membership or other penalty. In addition, I understand and agree that the City of Longview may cancel this agreement at any time by giving me 30 days’ advance notice of cancellation. If the City of Longview chooses to cancel this agreement, the city will refund to me a portion of my annual Membership fee based on the amount of time remaining in the calendar year.

Applicant Signature: _____ Date: _____

Spouse’s Signature: _____ Date: _____