Skiatook EMS *Department*

EMS SUBSCRIPTION
July 1, 2020 June 30, 2021

AMBULANCE MEMBERSHIP PROGRAM

Name: _____ Date of Birth ____/____/_____

Address_____ SS #_____-_____-_____

City _____ State_____ Zip _____Phone ( ) _____-_____

List the full and correct names of all members of your household other than yourself. Indicate the relation to yourself, their date(s) of birth and social security numbers, to the best of your knowledge.

NAME	DOB	SS#	RELATION

List any additional name(s) and information on a separate sheet of paper and affix to this form.

Insurance Carrier: _____**Policy #**_____ **Group** _____
(Company Name)

Medicare #_____ **Medicaid #**_____

List any additional or secondary insurance carriers on a separate sheet of paper and affix to this form.

Is your family covered on your policy? Yes__ No __ Does your spouse have family coverage? Yes __No__

Insurance Claims: This membership plan is ***not insurance.*** All insurance, Medicare and Medicaid claims will be processed by this service. All insurance, Medicare & Medicaid will be paid directly to this department.

ANNUAL FEE $84.00

If you have questions about the coverage area, or additional membership requirements, please call 918-396-3820

Make Checks Payable to: **City of Skiatook P.O. Box 399 Skiatook, OK 74070**