AMR AMBU-CARE MEMBERSHIP CONTRACT

Want to join immediately? Sign-up online at: www.amr-westmi.com

I understand that I must use the services of AMR West Michigan (AMR) in order to be eligible for benefits provided by this membership. I understand that the membership fee provides me and my qualified family members emergency and non-emergency ambulance service. I request payment of authorized Medicare or other insurance benefits be made on my behalf to AMR for any ambulance services and supplies furnished to me by AMR, whether in the past, now or in the future. If any insurance provider sends a check for services provided by AMR to the member, it is agreed that such check will be promptly sent to AMR. I authorize any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contractors, as well as AMR, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, whether in the past, now or in the future.

The membership fee constitutes prepayment by the Member of all deductible, copayment and other charges which are not paid by the Member's health insurance, such as Medicare, a PPO, an HMO, or other third-party sources such as a homeowners or automobile policy (collectively, "Insurance") for Covered Transports, as defined herein. AMR shall accept the amounts paid by the Member's Insurance as payment in full for such transports. Members shall not incur any out of pocket costs for Covered Transports, except as provided below. As a condition of receiving the full benefit of membership above, a member must have Insurance for a Covered Transport. Members who do not have Insurance for a Covered Transport will receive a discount equal to 20% AMR's billed charge. I further understand that all services which are determined to be not medically necessary, not covered by my insurance, or other than to or from a hospital are rendered at a membership discount rate of 20%.

I also understand that emergency calls have first priority, and the need for medical transportation will be determined by the medical staff of AMR, and that routine medical transfers require physician authorization. This membership covers ground transportation only.

I understand that this membership is non-refundable and non-transferable. This membership takes effect two days after AMR's business office receives my completed and signed membership application and my annual membership fee.

I affirm that I have read and agree to the terms of this membership as described in the above "AMR Ambu-Care Membership Contract." This membership contract remains in effect for one year.

X_____ X_____ Date_____

Your Signature — Spouse's Signature (only if legally married)

NAMES OF COVERED MEMBERS

(self, spouse, and anyone that is claimed on your taxes as a dependent)

For Office Use Only	First Name	Last Name	D.O.B	M or F	Social Security #

Mailing Address: **Phone:**

City: **State:** **Zip:**

c/o (if needed) **Email Address:**

☐ ***My Check or Money Order for $40 made payable to AMR is enclosed.***

☐ ***Please charge my credit card for the $40 annual fee. ** proceed to the next two lines ****

Exact Name on Card: **CVC Code:**

Credit Card Number: **Exp Date:**

Don't Forget

1. Read & Sign the Contract
2. Complete the Application
3. Mail Contract & Payment

AMR
Attn: GR New Membership
517 Division Ave South
Grand Rapids, MI 49503

For Office Use Only

Date Recd:_____

Pay Type:_____

Amount:_____

Want to Renew Online? ***www.amr-westmi.com***