Vital Care Partners

Membership Contract

I understand that the annual $37 per family membership fee provides emergency medical services and ambulance transportation at no additional out-of-pocket cost to me, provided it is medically necessary. The Vital Care Partners program covers spouse and minor children (or eligible dependents) living at the same address. If you prefer, we also have a "4 for 3" membership (if you pay for 3 years $111.00) - you get a fourth year free.

I request that payment of authorized insurance benefits be made on my behalf to Wayland Area EMS for any ambulance services provided to me or my listed dependents. I authorize any holder of medical information or documentation about me to release to any insurance company, governmental or third party agency as well as to Wayland Area EMS, any Information or documentation needed to determine these benefits, or benefits payable for related services, or any services provided to me by Wayland Area EMS now or in the future. In the event that my insurance carrier remits directly to me, I will promptly turn over payment directly to Wayland Area EMS,

Wayland Area EMS retains the right to bill Medicare, Medicaid and private insurance companies for services provided. This program is subject to changes in Medicare reimbursement and may not be changed or terminated without notice. This is not an insurance program and does not reduce the obligations of any third party payer.

I understand that the Wayland Area EMS Vital Care Partners membership services are limited to "medically necessary" transportation, where ambulance transportation to and from a health care facility (nursing home) is indicated by the patient's condition and where alternate forms of transportation would be normally inappropriate. I understand that Long-distance non-emergency transfers may result in additional fees being charged by Wayland Area EMS, I understand that physician authorization is required for all routine medical transfers to and from hospitals.

I understand that the Vital Care Partners membership is effective on receipt of full payment and signed membership contract. You may enroll at any time, but the membership runs from June 15 - June 15, I understand that this membership is non-refundable and is not transferable. Wayland Area EMS reserves the right to terminate this agreement if abuse is found to exist. For additional Information, call Wayland Area EMS at 792-2958.

Member Information

Last Name	Last Name	Birth date	Male Female
Local Address	Apt/lot	City	Zip
Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Medicare Number	___ ___ - ___ ___ - ___ ___ ___ ___ ___	
Spouse's Name	Last Name	Birth date	Male Female
Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Medicare Number	___ ___ - ___ ___ - ___ ___ ___ ___ ___	

Dependent Information

Name	Birth Date	Sex	Social Security Number
			___ ___ ___ - ___ ___ - ___ ___ ___ ___
			___ ___ ___ - ___ ___ - ___ ___ ___ ___
			___ ___ ___ - ___ ___ - ___ ___ ___ ___
			___ ___ ___ - ___ ___ - ___ ___ ___ ___
			___ ___ ___ - ___ ___ - ___ ___ ___ ___

Mail Both Pages to : Wayland Area EMS
911 S Main St
Wayland, MI 49348

Plan [ ] Annual $37.00 [ ] New Member
[ ] 4 for 3 $111.00 [ ] Current member
Payment type [ ] Check [ ] Credit Card (mastercard/visa)

Credit Card Number _____

Signature _____

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Insurance Information

Member's Health Insurance Carrier [ ] Primary [ ] Secondary	Policy Number
Agent or Insurance Address	
Member's Auto Insurance Carrier [ ] Primary [ ] Secondary	Policy Number
Agent or Insurance Address	
Member's Employer (if insured through employer)	
Address	

By signing this form I agree to the terms of the above agreement and give permission to Wayland Area EMS to forward any of my medical or personal information or that of my minor dependants to the stated insurance providers to obtain payment for services rendered.

Member's Signature Date

Spouse's Health Insurance Carrier [ ] Primary [ ] Secondary	Policy Number
Agent or Insurance Address	
Spouse's Auto Insurance Carrier [ ] Primary [ ] Secondary	Policy Number
Agent or Insurance Address	
Spouse's Employer (if insured through employer)	
Address	

By signing this form I agree to the terms of the above agreement and give permission to Wayland Area EMS to forward any of my medical or personal information or that of my minor dependants to the stated insurance providers to obtain payment for services rendered.

Spouse's Signature Date

Dependant 1 Health Insurance Carrier [ ] Primary [ ] Secondary	Policy Number
Dependant 2 Health Insurance Carrier [ ] Primary [ ] Secondary	Policy Number
Dependant 3 Health Insurance Carrier [ ] Primary [ ] Secondary	Policy Number
Dependant 4 Health Insurance Carrier [ ] Primary [ ] Secondary	Policy Number
Dependant 5 Health Insurance Carrier [ ] Primary [ ] Secondary	Policy Number