

**2021 EMS AID\* APPLICATION COMPLETE BOTH SIDES OF THIS FORM**

HEAD OF HOUSEHOLD				OTHER HOUSEHOLD MEMBER				
Last Name, First Name, Middle Initial				Last Name, First Name, Middle Initial				
Address				City		State	Zip	
Phone Number		Volunteer Organization		Relationship				
Date of Birth		Social Security Number		Date of Birth		Social Security Number		
Name of <b>PRIMARY</b> Insurance Policy				Name of <b>PRIMARY</b> Insurance Policy				
Address for <b>PRIMARY</b> Insurance Policy				Address for <b>PRIMARY</b> Insurance Policy				
Insurance I.D. Number		Insurance Group #		Insurance I.D. Number		Insurance Group #		
OTHER INSURANCE				OTHER INSURANCE				
Name of <b>SECONDARY</b> Insurance Company				Name of <b>SECONDARY</b> Insurance Company				
I.D. Number		Insurance Group #		I.D. Number		Insurance Group #		
Address for Group Insurance Policy Claim				Address for Group Insurance Policy Claim				
Additional Members Residing At Your Address - Attach Separate Sheets if Necessary								
Last Name, First Name, Middle Initial			#	Last Name, First Name, Middle Initial			#2	
Social Security Number		Date of Birth	Relationship		Social Security Number		Date of Birth	Relationship
<b>Insurance if Different from Head of Household</b>				<b>Insurance if Different from Head of Household</b>				
Name of <b>PRIMARY</b> Insurance Policy		Insurance I.D. #		Name of <b>PRIMARY</b> Insurance Policy		Insurance I.D. #		
Address for Primary Insurance Policy Claim				Address for Primary Insurance Policy Claim				
Last Name, First Name, Middle Initial			#	Last Name, First Name, Middle Initial			#4	
Social Security Number		Date of Birth	Relationship		Social Security Number		Date of Birth	Relationship
<b>Insurance if Different from Head of Household</b>				<b>Insurance if Different from Head of Household</b>				
Name of <b>PRIMARY</b> Insurance Policy		Insurance I.D. #		Name of <b>PRIMARY</b> Insurance Policy		Insurance I.D. #		
Address for Primary Insurance Policy Claim				Address for Primary Insurance Policy Claim				

A new form is **required annually** to participate in the program. Please sign the Assignment of Benefits Authorization & return this form with your \$59.00 payment.

Check Payable to: Prince George County Fire & EMS

**Mail To:**

Prince George Fire & EMS

P. O. Box 185

Prince George, Virginia 23875

Your subscription will be effective after receipt of your application and payment.

For assistance, call (804) 722-8623

Assignment of Benefits Authorization

I understand that I am financially responsible for the services provided to me by Prince George County Fire & EMS (PGFEMS) regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to PGFEMS or its billing agent for any services provided to me by PGFEMS. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services and its carriers and agents, as well as to PGFEMS and its billing agents, any information or documentation needed to determine these benefits, or benefits payable for any services provided to me by PGFEMS, now or in the future. I agree to immediately remit to PGFEMS any payments that I receive directly from any source for the services provided to me. A copy of this form is as valid as the original.

PGFEMS is required by law to maintain the privacy of certain confidential health-care information, known as Protected Health Information, or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. You also have certain rights under federal law regarding your PHI. Our legal duties and privacy practices, and your rights regarding your PHI, are described in our Notice of Privacy Practices, a copy of which can be supplied to you.

I acknowledge that I have received a copy of the *PGFEMS Notice of Privacy Practices* and authorize the assignment of benefits.

All individuals over the age of 18 who are enrolled in the EMS AID Program must sign below.

Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_

Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_

Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_

Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_

Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_

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Power of Attorney for the Individual(s) Listed Below: (Attach Written Power of Attorney)

Name of Individual (Print Name): \_\_\_\_\_

Power of Attorney (Attorney in Fact): \_\_\_\_\_ Date: \_\_\_\_\_

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Power of Attorney for the Individual(s) Listed Below:

Name of Individual (Print Name): \_\_\_\_\_

Name of Individual (Print Name): \_\_\_\_\_

Name of Individual (Print Name): \_\_\_\_\_ Date: \_\_\_\_\_