

# HUSTONTOWN AMBULANCE CLUB

Check One:    New     Renewal

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Apt.# \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Family Subscription Rate            \$35.00  
Individual Subscription Rate        \$30.00

**CHOOSE APPROPRIATE RATE**

Make Checks Payable To:  
HAVFCO Ambulance Club  
P.O. Box 537  
Hustontown, PA 17229

Subscription Rate \_\_\_\_\_  
Donation (Optional) \_\_\_\_\_  
Total Enclosed \_\_\_\_\_

*Please list below the family members residing in your home.*

_____	_____
_____	_____
_____	_____
_____	_____

### AUTHORIZATION

I authorize that payment of Medicare or other insurance benefits be made on my behalf to Hustontown Ambulance for any ambulance services provided to me by Hustontown Ambulance. I authorize any holder of medical information or documentation about me to release to the Health Care Financing Administration and its carriers and agents, as well as to Hustontown Ambulance, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by Hustontown Ambulance now or in the future. Each Medicare card recipient should sign below.

SIGNATURE X \_\_\_\_\_

SIGNATURE X \_\_\_\_\_

***SIGN AND RETURN THIS COMPLETED FORM WITH PAYMENT***

Hustontown Area Vol. Fire Co. 2009 Ambulance Company Membership Card
Emergency Dial 911
2009 <b>MEMBERSHIP CARD &amp; SUBSCRIPTION RECEIPT</b>
Check No _____ Date _____
EXPIRES DECEMBER 31, 2009
<i>Detach and retain this for your records</i>

The subscription entitles holder  
**UNLIMITED EMERGENCY  
MEDICAL SERVICE.**

Hustontown Ambulance reserves  
the right to any available third party  
billings.

Your membership covers non-  
emergency transports from hospital  
to hospital only at your request.

**ADDITIONAL INFORMATION  
PLEASE  
CALL 717-987-3783**