

SUBSCRIBER MEMBER: 2020 \$29.00 Single Member / \$59.00 Family

Name		
Address and P.O. Box		
City, State, Zip	Phone	
Social Security Number	Date of Birth	
HEALTH PLAN: Group number and/or policy number including Medicare/Medicaid		

**ADDITIONAL FAMILY MEMBER(S) RESIDING AT YOUR ADDRESS:
(ATTACH SEPARATE SHEET IF NECESSARY) Please fill in all blanks needed for billing**

Name, First Last	Social Security Number	
Date of Birth	Relation to subscriber	
HEALTH PLAN: Group number and/or policy number including Medicare/Medicaid: If different than subscriber member		
Name, First Last	Social Security Number	
Date of Birth	Relation to subscriber	
HEALTH PLAN: Group number and/or policy number including Medicare/Medicaid: If different than subscriber member		
Name, First Last	Social Security Number	
Date of Birth	Relation to subscriber	
HEALTH PLAN: Group number and/or policy number including Medicare/Medicaid: If different than subscriber member		
Name, First Last	Social Security Number	
Date of Birth	Relation to subscriber	
HEALTH PLAN: Group number and/or policy number including Medicare/Medicaid: If different than subscriber member		

TO ADD OR REMOVE A MEMBER PLEASE CALL (804) 469-5388

DO NOT WRITE BELOW THIS LINE: OFFICE USE ONLY

Ambulance Aid Program

2020

CREDIT CARD

CASH	CHECK #	ELIGIBILITY DATE

AMOUNT PAID

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