PRIORITY™
AMBULANCE

PRIORITY AMBULANCE SUBSCRIPTION PROGRAM

Take the financial stress out of calling an ambulance.

Priority Ambulance understands that medical transportation can be an unexpected, costly expense. To financially safeguard your family against unforeseen medical emergencies, we offer an affordable annual subscription plan.

Priority Ambulance's subscription program covers the out-of-pocket costs of any medically necessary transport. Our subscription program is not health insurance and does not replace your primary insurance. In the event of a medical emergency, a subscriber's primary insurance would be billed. Any additional balances, deductibles or co-pays not covered by the insurance for services deemed medically necessary by a physician would be covered through Priority Ambulance's subscription agreement.

Join the Priority Ambulance care network, and let us help you protect your family's physical and financial health in an emergency.

NAME: _____

ADDRESS: _____

CITY: _____ APT. NO.: _____

STATE: _____ ZIP: _____ PHONE (____) _____-_____

AMOUNT OF PAYMENT: $ _____ (2015 rate is $60)

METHOD OF PAYMENT:

☐ CASH ☐ CREDIT CARD (To make a credit card payment, please call 844-597-4911)

☐ PERSONAL CHECK ☐ MONEY ORDER (PLEASE DO NOT SEND CASH BY MAIL. MAKE CHECKS PAYABLE TO PRIORITY AMBULANCE)

PLEASE COMPLETE FOR EACH MEMBER OF THE HOUSEHOLD. (Each person 18 and older must sign this form for the agreement to be valid.)

NAME: _____

CUSTOMER #1: _____ SEX: ☐ F ☐ M

SIGNATURE: _____

PRIMARY INSURANCE: _____

GROUP #: _____

POLICY #: _____

SECONDARY INS: _____

GROUP#: _____

POLICY #: _____

SSN: _____-_____-_____ DOB: _____/_____/_____

RELATION TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

NAME: _____

CUSTOMER #2: _____ SEX: ☐ F ☐ M

SIGNATURE: _____

PRIMARY INSURANCE: _____

GROUP #: _____

POLICY #: _____

SECONDARY INS: _____

GROUP#: _____

POLICY #: _____

SSN: _____-_____-_____ DOB: _____/_____/_____

RELATION TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

NAME: _____

CUSTOMER #3: _____ SEX: ☐ F ☐ M

SIGNATURE: _____

PRIMARY INSURANCE: _____

GROUP #: _____

POLICY #: _____

SECONDARY INS: _____

GROUP#: _____

POLICY #: _____

SSN: _____-_____-_____ DOB: _____/_____/_____

RELATION TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

NAME: _____

CUSTOMER #4: _____ SEX: ☐ F ☐ M

SIGNATURE: _____

PRIMARY INSURANCE: _____

GROUP #: _____

POLICY #: _____

SECONDARY INS: _____

GROUP#: _____

POLICY #: _____

SSN: _____-_____-_____ DOB: _____/_____/_____

RELATION TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER