LIFESAVER

AMBULANCE • MEMBERSHIP • PLAN

Please Select One: ❑ **2018 RENEWAL** ❑ **NEW MEMBER**

Enrolling in the LifeSaver Membership Plan helps cover the cost of emergency (9-1-1) ambulance service for Richmond City residents from January 1, 2018 through December 31, 2018. Send the completed form and your payment to the address listed on the back. Your LifeSaver membership approval letter will be sent to you in a few weeks.

PLEASE READ THE ATTACHED PLAN INFORMATION AND SIGN THE BACK OF THIS FORM.

HEAD OF HOUSEHOLD

Name (Last, First)

Address

City, State, Zip

Phone | RAA LifeSaver Membership Number, if applicable

Social Security Number | Date of Birth | Medicare Number, if applicable

PRIMARY INSURANCE

Name of Insurance Company | Group Number | ID Number

Address for Insurance Policy Claim

OTHER INSURANCE

Name of Insurance Company | Group Number | ID Number

Address for Insurance Policy Claim

OTHER FAMILY MEMBER

Name (Last, First)

Social Security Number | Date of Birth

Relation | Medicare Number, if applicable

PRIMARY INSURANCE

Name of Insurance Company

Group Number | ID Number

Address for Insurance Policy Claim

OTHER INSURANCE

Name of Insurance Company

Group Number | ID Number

Address for Insurance Policy Claim

ADDITIONAL DEPENDENTS RESIDING AT YOUR ADDRESS – Attach Separate Sheet If Necessary

Additional Member #1 Name (Last, First)

Social Security Number | Date of Birth | Relation

Insurance, if different from Head of Household

Name of Insurance Company | Group Number | ID Number

Address for Insurance Policy Claim

Additional Member #2 Name (Last, First)

Social Security Number | Date of Birth | Relation

Insurance, if different from Head of Household

Name of Insurance Company | Group Number | ID Number

Address for Insurance Policy Claim

Additional Member #3 Name (Last, First)

Social Security Number | Date of Birth | Relation

Insurance, if different from Head of Household

Name of Insurance Company | Group Number | ID Number

Address for Insurance Policy Claim

Additional Member #4 Name (Last, First)

Social Security Number | Date of Birth | Relation

Insurance, if different from Head of Household

Name of Insurance Company | Group Number | ID Number

Address for Insurance Policy Claim

Patient Privacy: RAA cares about protecting its patients' privacy. In accordance with the Health Insurance Portability & Accountability Act (HIPAA) of 1996, RAA will provide you with an explanation of your patient rights and how your medical information will be used by the Authority. For a complete list of RAA Privacy Practices, visit www.raaems.org or call the business office at 804-254-1150.

MEMBERSHIP FEES AND BENEFITS

The Richmond Ambulance Authority (RAA) LifeSaver Membership Plan (PLAN) covers member's insurance co-pays and deductibles for any emergency transport during the membership year. If the member does not have insurance coverage or if their insurance does not cover the emergency ambulance transport, the PLAN provides a 20% discount off the charge of the transport for members.

The annual membership fee is $49 for an individual and $79 for a family.

EFFECTIVE DATES

I understand my membership is effective upon receipt by RAA of full payment ($49 for an individual or $79 for a family) and signed membership agreement for the period January 1, 2018 through December 31, 2018. Applications received by RAA after the start of the membership year will become effective 30 days after receipt and the fee will not be prorated. To get the maximum membership benefits, **make sure your application and payment is postmarked by December 31, 2017.**

MEMBERSHIP TERMS

- I understand the PLAN covers members listed on the application, and that a family is defined as a member and their dependents that permanently live at the member's physical place of residence (same household/address).
- I understand that the member is responsible for notifying RAA of the addition of any dependents during the membership year due to birth, adoption, or marriage. Benefits for dependents added after January 1, 2018 become effective 30 days after receipt of notification of the change by RAA.
- I understand the PLAN is only open to residents that live within the city limits of Richmond, Virginia.
- I understand Medicaid recipients do not need to enroll in the LifeSaver Plan.
- I understand the PLAN does not cover non-emergency transports.
- I also understand this membership is nontransferable and the fee is nonrefundable.
- **I acknowledge I am responsible for payment of ambulance services for me or my dependents regardless of insurance coverage. I understand the PLAN is not insurance and RAA will claim payments from my insurer or third-party agency (e.g., Medicare). I understand I may be asked to help RAA collect these benefits or payments. If I receive a payment directly from an insurance company, I will immediately forward the payment to RAA under this agreement.**
- I, the undersigned, request payment of authorized benefits be made on my behalf to Richmond Ambulance Authority, 2400 Hermitage Road, Richmond, VA 23220 for any ambulance services provided to me by Richmond Ambulance Authority.
- I authorize any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid and its Agents and Carriers, as well as to Richmond Ambulance Authority, any information or documentation needed to
- determine these benefits or benefits payable for related services provided to me by Richmond Ambulance Authority, now or in
- the future.
- I certify I have read and agree to the terms of the membership agreement.

SIGN HERE X _____ Date _____

Membership agreement must be signed by the holder of Insurance Policy listed on other side or authorized person if uninsured.

METHOD OF PAYMENT

❑ Personal Check ❑ Money Order ❑ MasterCard ❑ VISA ❑ Discover

Credit Card #_____ Exp. Date _____

Name (print as appears on credit card) _____

Signature _____

(FOR CREDIT CARD PAYMENT ONLY)

Mail your Completed Form and Payment: ($49 for Individual or $79 for Family)

Richmond Ambulance Authority • 2400 Hermitage Road • Richmond, Virginia 23220

Received Date: _____ Check # _____ Amount: _____

Medicaid Checked: _____ Membership Card Mailed: _____