AMERICAN MEDICAL RESPONSE AIR MEMBERSHIP PROGRAM APPLICATION 2015-2016

MAIL THIS FORM AND PAYMENT TO AMERICAN MEDICAL RESPONSE AT THE FOLLOWING ADDRESS:

99-840 Iwaiwa Street Unit 1 Aiea, HI 96701

Please complete the additional blocks for the OTHER CURRENT HOUSEHOLD MEMBERS. ONLY LEGAL DEPENDENTS OF THE PRIMARY MEMBER ARE ELIGIBLE.

ADDITIONAL HOUSEHOLD MEMBER

First________________________MI____Last________________________SS#_________________Date of Birth__________

Relationship to Primary Member:________ If insurance coverage is the same as Primary Member, put "Same":__________

Primary Insurance:__________________________________Policy #__________________________Group #_____________

Insurance Billing Address:____Phone Number:____________

Secondary Insurance:______________________________Policy #___________________________Group #_____________

Insurance Billing Address:____Phone Number:____________

ADDITIONAL HOUSEHOLD MEMBER

First________________________MI____Last________________________SS#_________________Date of Birth__________

Relationship to Primary Member:________ If insurance coverage is the same as Primary Member, put "Same":__________

Primary Insurance:__________________________________Policy #__________________________Group #_____________

Insurance Billing Address:____Phone Number:____________

Secondary Insurance:______________________________Policy #___________________________Group #_____________

Insurance Billing Address:____Phone Number:____________

ADDITIONAL HOUSEHOLD MEMBER

First________________________MI____Last________________________SS#_________________Date of Birth__________

Relationship to Primary Member:________ If insurance coverage is the same as Primary Member, put "Same":__________

Primary Insurance:__________________________________Policy #__________________________Group #_____________

Insurance Billing Address:____Phone Number:____________

Secondary Insurance:______________________________Policy #___________________________Group #_____________

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ADDITIONAL HOUSEHOLD MEMBER

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Secondary Insurance:______________________________Policy #___________________________Group #_____________

Insurance Billing Address:____Phone Number:____________