MALVERN FIRE COMPANY EMS

You may complete this information for your records:

Date Sent _____ Amount $ _____ Check No. _____

Please refer to this number in any correspondence.

Please list names and sign back of form.
New volunteers are needed.
Call 610-647-0693 for details!

T009

002716

Includes Paramedic Services

Subscription Receipt

• 2023-2024 •

KEEP THIS PORTION FOR YOUR RECORDS

ALL EMERGENCY CALLS:

9 - 1 - 1

INFORMATION CALLS ONLY:

610-647-0693

www.malvernfireco.com

Detach Here

MALVERN FIRE COMPANY EMS

Circle the amount of your Subscription & return this portion.

INDIVIDUAL	FAMILY	SENIOR CITIZEN(S)	TOTAL
$90.00	$125.00	$50.00	$_____

Please refer to this number in any correspondence.

Please Make Any Necessary Corrections To Name & Address Below

• 2023-2024 •

Subscription Request

Make Checks Payable To:

MALVERN FIRE COMPANY EMS
424 EAST KING STREET
MALVERN PA 19355

[_]-PLEASE CORRECT NAME

Please complete back of form →

1503
1

RETURN THIS PORTION IN THE ENVELOPE PROVIDED

Detach Here

2023 - 2024 Subscription Fees:

Individual ---------- $ 90.00
Family ---------- $125.00
Senior Citizen(s) ---------- $ 50.00

Family is 2 or more individuals residing in the same household. For any level of subscription, be sure to complete the form on back.

Effective April 1, 2023 to March 31, 2024

1503

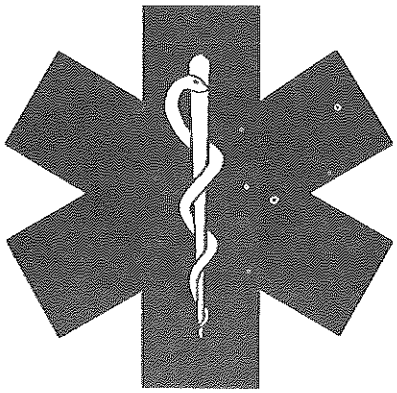
Please detach this card after mailing us your subscription fee.

SUBSCRIPTION CARD

MALVERN FIRE COMPANY EMS

EMERGENCY CALLS	**9 - 1 - 1**
ALL OTHER CALLS	610-647-0693
EXPIRES	March 31, 2024

REMOVE AND RETAIN SUBSCRIPTION CARD



Authorization

I understand that I am financially responsible for the services provided to me or my family members by this health service provider or supplier regardless of my insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to the health service provider or supplier or its billing agent for any services provided to me by the health provider or supplier. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Service and its carriers and agents, as well as to the health provider or supplier and its billing agents, any information or documentation needed to determine these benefits payable for any services provided to me by the health service provider, both now or in the future. A copy of this form is as valid as the original. I also agree to immediately remit to the health service provider any payments that I receive directly from any source for the services provided to me.

Signature_____ **Date** _____

Please list all family members residing at this address to be covered by this membership.	Date of Birth

Remember: Always wear your seat belt and make sure children are properly secured.

This membership entitles the holder unlimited **Emergency Medical Service** within the coverage area, subject to the subscription terms and conditions, available upon request.

-THANK YOU FOR YOUR SUPPORT-