SUNSTAR FirstCare Ambulance Membership Plan

Application and Agreement

Member Information Please read Membership Agreement on reverse prior to signing The application must be signed by all members 18 years of age and over		
Primary Member's Full Name and Address:	**Social Security #:**	**Birth Date:**
	Change of Address:	
Signature:	**Date:**	**Phone:**
Family Member #1 Name:	**Social Security #:**	**Birth Date:**
Signature:	**Date:**	**Phone:**
Family Member #2 Name:	**Social Security #:**	**Birth Date:**
Signature:	**Date:**	**Phone:**
Family Member #3 Name:	**Social Security #:**	**Birth Date:**
Signature:	**Date:**	**Phone:**
Family Member #4 Name:	**Social Security #:**	**Birth Date:**
Signature:	**Date:**	**Phone:**

Insurance Information		
Primary Insurance Name:	**ID/Contract#:**	**Applies to: ☐Primary ☐Family #1 ☐Family #2 ☐Family #3 ☐Family #4**
Secondary Insurance Name:	**ID/Contract#:**	**Applies to: ☐Primary ☐Family #1 ☐Family #2 ☐Family #3 ☐Family #4**

Payment Information FOR YOUR SECURITY, CREDIT CARD PAYMENTS ARE NO LONGER ACCEPTED BY MAIL		
Please check one:	○ **$98.00 Family**	◉ **$63.00 Single**
Check #:		**Money Order#:**

RETURN THIS FORM WITH CHECK OR MONEY ORDER

Use a separate piece of paper if necessary to add additional family members and/or additional insurance information

For more information, please visit our website at:

http://www.pinellascounty.org/FirstCare

Or contact our office at (727) 582-2008

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ENROLLMENT FEE: I acknowledge that I am responsible for the payment of ambulance services provided to me by Sunstar and my Membership fee for the Sunstar FirstCare Ambulance (Plan) covers my copayments and deductibles. If my claim is denied by my primary insurance carrier, the Plan provides me a discount of 50% off my ambulance bill. **If I DO NOT have insurance, including Medicare or Medicaid**, the Plan provides me **a discount of 20%** off my ambulance bill. Annual Membership fees are: Single Person Membership is **$63**; Family Membership is **$98**. Please make check or money order payable to Sunstar and mail check with your completed application to: Sunstar at P.O. Box 31074, Tampa, FL 33631-3074.

MEMBERSHIP PLAN COVERAGE: The Plan covers ambulance transports originating and ending in Pinellas County by Sunstar ambulance units only. The Membership does not cover transports via Sunstar's Mental Health Transport Van.

ELIGIBLE FAMILY PLAN MEMBERS: The Family Membership Plan covers family members related by blood, adoption, or marriage who permanently reside in the same household as the primary member.

BILLING OF PRIMARY INSURANCE: I acknowledge that I am responsible for paying ambulance services provided to me by Sunstar, except those eligible under the Membership Plan. I acknowledge that Sunstar will file claims on my behalf with my primary and secondary (if applicable) insurance carrier(s) including Medicare. I herein assign my right to reimbursement for covered transports to Sunstar.

INSURANCE PAYMENT OF CLAIMS: I authorize payment resulting from claims billed on my behalf be made directly to Sunstar. In the event I receive payment directly from my insurance company related to the transport, I agree to endorse the check, include explanation of benefits and mail to: Sunstar at P.O. Box 31074, Tampa, FL 33631-3074. If I do not forward the payment to Sunstar, I understand I will receive a bill and be responsible for the payment of this amount.

RELEASE OF MEDICAL INFORMATION: As a part of the billing process, I authorize release of any holder of medical information about me or other relevant documentation about me to release to Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contracts, as well as Sunstar, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related service, whether in the past, now or in the future.

EFFECTIVE DATES: New Memberships: Completed applications with payment in full, received prior to the end of the calendar year, will be effective on January 1st. Completed applications with payment in full received after January 1st, will be effective on the postmark date. Renewals: Completed applications with payment in full (received prior to April 1st) will be effective April 1st. All memberships expire on March 31st of the following year. Members whose applications are received or postmarked after March 31st will not have coverage for the full 12-month period and Membership fees will not be pro-rated.

REFUNDS: I acknowledge that Membership fees are non-refundable and are used to cover the cost of administering the Plan and processing my application. I am therefore not entitled to any refund of monies paid to Sunstar under this agreement after the agreement's effective date.

NEED FOR PLAN COVERAGE: If I have medical insurance, I acknowledge that I have reviewed my coverage under my primary insurance carrier as it pertains to ambulance transportation and have made a voluntary determination to enroll in the Plan, as some primary insurance carriers cover 100% of ambulance transportation. No enrollment fee will be refunded after the effective date, should an enrollee subsequently determine coverage is not desired or needed.

PROOF OF MEMBERSHIP: Your check or credit card statement is your receipt. Membership cards are unnecessary, and are not issued. If you are transported, your Membership will be verified by Sunstar.

BY SIGNING THE MEMBERSHIP PLAN APPLICATION & AGREEMENT, I AGREE TO ABIDE BY THE TERMS HEREOF.