

**PAYMENT & SIGNED APPLICATION MUST BE POSTMARKED ON OR BEFORE 3-31-2010**

Primary Member's Name:	Social Security #	Birth Date:
Family Member's Name:	Social Security #	Birth Date:
Family Member's Name:	Social Security #	Birth Date:
Family Member's Name:	Social Security #	Birth Date:
Family Member's Name:	Social Security #	Birth Date:

Use a separate piece of paper if necessary to add additional family members.

Mailing address: _____																					
City: _____	State: _____ Zip: _____																				
Phone: (        ) _____																					
<table border="1"> <tr> <td colspan="2"><b>PAYMENT VIA CHECK OR MONEY ORDER CHECK #</b> _____</td> </tr> <tr> <td>Please check one:</td> <td>(    ) \$45 Single Membership</td> </tr> <tr> <td></td> <td>(    ) \$70 Family Membership</td> </tr> <tr> <td colspan="2"><b>CREDIT CARD PAYMENT (    ) VISA or (    ) MASTERCARD</b></td> </tr> <tr> <td>Please check one:</td> <td>(    ) \$45 Single Membership</td> </tr> <tr> <td></td> <td>(    ) \$70 Family Membership</td> </tr> <tr> <td>Card #</td> <td>_____</td> </tr> <tr> <td>Expiration Date</td> <td>_____</td> </tr> <tr> <td>Name of Cardholder</td> <td>_____</td> </tr> <tr> <td>Authorized Signature</td> <td>_____</td> </tr> </table>		<b>PAYMENT VIA CHECK OR MONEY ORDER CHECK #</b> _____		Please check one:	(    ) \$45 Single Membership		(    ) \$70 Family Membership	<b>CREDIT CARD PAYMENT (    ) VISA or (    ) MASTERCARD</b>		Please check one:	(    ) \$45 Single Membership		(    ) \$70 Family Membership	Card #	_____	Expiration Date	_____	Name of Cardholder	_____	Authorized Signature	_____
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The application must be signed by all members 18 years of age and over.

**RETURN THIS PORTION WITH PAYMENT**

**SUNSTAR FIRSTCARE MEMBERSHIP PLAN**

Please read before signing and retain this copy for your records

**INFORMATION: (727) 582-2008**

**ENROLLMENT FEE:** I understand that the membership fee for SUNSTAR FirstCare limits my out-of-pocket expense for the uninsured portion of SUNSTAR ambulance bill(s) for medically necessary ambulance transportation. **If I have Medicare or Insurance, my membership takes care of my out of pocket expense for such services. If I DO NOT have Medicare or Insurance, membership provides me with a discount of 20% off SUNSTAR's usual charges for medically necessary ambulance transports.** Single Person Membership is \$45. Family Membership is \$70. Make check or money order payable to SUNSTAR and mail to P.O. Box 31074, Tampa, FL 33631-3074

**WHAT IS MEDICALLY NECESSARY:** "MEDICALLY NECESSARY" means there must be a specific medical need for an ambulance, or Advanced Life Support (ALS) crew, to or from a medical facility for medical treatment using Medicare standards. SUNSTAR REQUIRES PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY WHEN A TRANSPORT IS DENIED, OR EXPECTED TO BE DENIED BY A MEMBER'S INSURANCE, OR WHEN THERE IS REASON TO BELIEVE THE SERVICE IS NOT MEDICALLY NECESSARY, OR ABUSE IS SUSPECTED. If physician certification is not received **within 60 days from the date of the insurance denial**, the member will receive a bill for the full cost of the ambulance transport. In cases of repeated abuse, Membership will be terminated. Sunstar also reserves the right to require physician certification of medical necessity for all non-emergency transports.

**WHAT DOES MY MEMBERSHIP COVER:** The membership covers medically necessary ambulance transports originating and ending in Pinellas County, by Sunstar Ambulance units only. The membership does not cover ambulance services outside Pinellas County, or transports via Sunstar's Mental Health Transport Van.

**WHO IS COVERED IN A FAMILY PLAN:** The family membership plan covers family members related by blood or marriage who permanently reside in the same household as the primary member.

**IF I HAVE INSURANCE WHO WILL RECEIVE CLAIM PAYMENTS:** I understand that I am responsible for paying ambulance services provided to me by SUNSTAR except as provided in this Membership Contract. I understand that SUNSTAR will file claims with all third party insurers including Medicare. **I hereby assign my right to reimbursement for covered transports to SUNSTAR. If I receive payment directly from an insurer, I agree to promptly send those funds to SUNSTAR.**

To help process ambulance claims, I authorize release of any medical information necessary to process a claim, and further authorize such payment to be made directly to SUNSTAR. In the event I receive payment from my insurance company, I will endorse the check and mail directly 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 for this amount.

**EFFECTIVE DATES:** I understand that completed and signed applications received in November and December, with payment in full, will be effective January 1, 2010. Completed and signed applications received after January 1, 2010 with payment in full, will be effective on the postmark date. Payment must be postmarked on or before March 31, 2010, to guarantee rights under this contract. Membership under this agreement will expire on March 31, 2011.

**REFUNDS:** I also agree that upon termination of this agreement, my membership fee will be 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 prior to or after the agreement's effective date.

**NEED FOR COVERAGE:** By applying for membership in the plan I understand that the responsibility for determining my need for coverage is mine. No enrollment fee will be refunded if subsequent to applying for membership, enrollee determines coverage is not desired. **Since Medicaid pays 100% of COVERED ambulance services required by persons enrolled in that program, Medicaid beneficiaries need not enroll in this program. Any payments, or membership fees, received from Medicaid Beneficiaries will be deemed to be voluntary contributions to SUNSTAR.**

**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 our staff.

**BY SIGNING THE ABOVE, I AGREE TO ABIDE BY THE TERMS HEREOF.**

For more information, please visit our web site(s) at:  
<http://www.sunstarems.com>  
<http://www.pinellascounty.org/EMS/default.htm>