Annual Ambulance Aid Enrollment Form
Membership Year 2024

Annual Membership Fee - I am eligible for this plan because I live or work in Dinwiddie County. I understand that the **annual membership fee** for Dinwiddie County Ambulance Aid Membership plan covers my out-of-pocket expense for Dinwiddie County's charge(s) for emergency medical transport as defined by my health plan, including costs for co-insurance and deductibles not covered by my health plan. Transportation from the hospital to another location is **not** covered in this membership.

Annual Membership Terms - Terms of the Ambulance Aid Membership Plan are as following...

1. The Plan is available to all residents of Dinwiddie County and the family members who live in the resident's household (provided that they are enrolled in the plan at time of application) and to individuals who work in the County.
2. The Plan covers medically necessary (as defined in the health plan) ambulance transport services to the hospital provided by Dinwiddie County. Transports from the hospital are not included in this plan.
3. I further understand that Dinwiddie County does not provide non-emergency transportation or wheelchair transportation.
4. The Plan only pays for the cost not covered by a health plan. Dinwiddie County will submit a claim for payment to the health plan for each ambulance transport.
5. Plan members agree to assist the County in collecting payments from the health plan by promptly providing necessary information and signatures for the submission of claims to the health plans and any other requirements which may be reasonably necessary to help Dinwiddie County collect payment.
6. If the Plan member receives a payment for the ambulance transport directly from the health plan the member will immediately forward such payment to Dinwiddie County. The failure to remit this payment to Dinwiddie County within five days of receipt will result in the full cost of the ambulance transport being borne by the plan member.
7. The Plan membership will **be effective upon receipt of full payment and a signed membership contract from January 1, 2024 thru December 31, 2024.**
8. The membership fee is non-refundable and non-transferable.
9. I, the undersigned request that payment of authorized benefits be made on my behalf to: **Dinwiddie County Fire & EMS at PO Box 637832 Cincinnati, OH 45263** for any ambulance services provided by Dinwiddie County.
10. I authorize any holder of medical information or documentation about me to release any information or documentation needed to determine these benefits or benefits payable for related services provided to me by Dinwiddie County now or in the future.

NOTICE: In the event your check is dishonored or returned for any reason, you authorize us to electronically (or by paper draft) re-present the check on your bank account for the collection of the amount of the check plus any applicable fees as permitted by law.
THE USE OF A CHECK FOR PAYMENT IS YOUR ACCEPTANCE OF THIS POLICY

BY SIGNING THIS FORM AND PAYING MY MEMBERSHIP FEE, I AGREE TO THE TERMS LISTED ABOVE.

_____ _____
Signature Date

_____
Printed Name

METHOD OF PAYMENT: $29.00 Single Member / $59.00 for a Family

Please Check One: ☐ **PERSONAL CHECK** ☐ **MONEY ORDER**
Payable to: Treasurer, County of Dinwiddie
Mailed to Dinwiddie Fire & EMS at P.O. Box 371 Dinwiddie, VA 23841

PLEASE FILL IN FOR MASTERCARD OR VISA CHARGES
Account number from your credit card: (please be advised that there will be a 3% processing fee included)

Please Circle One: **VISA** **MASTERCARD**

Cardholder Name: _____ Expiration Date: _____

Address: _____

Daytime Telephone Number: Area Code (_____) _____ Extension: _____

Cardholder Signature: _____

SUBSCRIBER MEMBER: 2024 $29.00 Single Member / $59.00 Family

Name	
Address and P.O. Box	
City, State, Zip	Phone
Social Security Number	Date of Birth
HEALTH PLAN: Group number and/or policy number including Medicare/Medicaid	

ADDITIONAL FAMILY MEMBER(S) RESIDING AT YOUR ADDRESS:

(ATTACH SEPARATE SHEET IF NECESSARY) **Please fill in all blanks needed for billing**

Name, First Last	Social Security Number
Date of Birth	Relation to subscriber
HEALTH PLAN: Group number and/or policy number including Medicare/Medicaid: If different than subscriber member	
Name, First Last	Social Security Number
Date of Birth	Relation to subscriber
HEALTH PLAN: Group number and/or policy number including Medicare/Medicaid: If different than subscriber member	
Name, First Last	Social Security Number
Date of Birth	Relation to subscriber
HEALTH PLAN: Group number and/or policy number including Medicare/Medicaid: If different than subscriber member	
Name, First Last	Social Security Number
Date of Birth	Relation to subscriber
HEALTH PLAN: Group number and/or policy number including Medicare/Medicaid: If different than subscriber member	

TO ADD OR REMOVE A MEMBER PLEASE CALL (804) 469-5388

DO NOT WRITE BELOW THIS LINE: OFFICE USE ONLY

Ambulance Aid Program

2024

CREDIT CARD	CASH	CHECK #	ELIGIBILITY DATE

AMOUNT PAID