

SUBSCRIPTION TYPE (PLEASE SELECT):

INDIVIDUAL (\$65) HOUSEHOLD (\$80)

ADDITIONAL DONATIONS ARE APPRECIATED

Make Checks Payable To:

Cumberland Goodwill EMS
c/o: Metro Bank
PO Box 4710
Harrisburg, PA 17111

PRIMARY SUBSCRIBER INFORMATION

Name: _____
Address: _____
Tel: _____
Email: _____

To pay by credit card, call
717-249-0012

Code: _____

PLEASE CORRECT NAME ON FILE
 PLEASE CORRECT ADDRESS ON FILE



DETACH BELOW - COMPLETE AND RETURN THE TOP PORTION ONLY - DETACH BELOW - COMPLETE AND RETURN THE TOP PORTION ONLY

Please Retain This Portion For Your Records

PLEASE DETACH AND KEEP THIS CARD

Membership Type Purchased:
Individual (\$65) Household (\$80)

Additional Donations Made: \$ _____

Total Amount Paid: \$ _____

Date Paid: ____/____/____

Payment Method: Cash Credit Check

Check Number: _____

**CUMBERLAND GOODWILL EMS
SUBSCRIPTION CARD**

Valid 1/1/2011 to 12/31/2011

For Emergencies: DIAL 9-1-1

All Other Calls: 717-249-0012

This card is only valid if the top portion is returned and payment is received

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 of supplier. I authorize and direct any holder of medical information or documentation about me to release to the Center for Medicare and Medicaid Services and its carriers and agents, as well as to this health provider or supplier and their 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 this health service provider any payments that I receive directly from any source for the services provided to me, now or in the future

Signature _____ **Date:** _____

PLEASE LIST ALL OTHER SUBSCRIBERS COVERED UNDER THE HOUSEHOLD PLAN	DATE OF BIRTH
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____