



# North Fork Ambulance

Crawford • Hotchkiss • Paonia

# Membership Application

Revised July 2017

### Select your desired membership level:

- Individual**..... **\$40/Year**  
Covers one individual residing full or part time in the North Fork Valley.
- Senior Citizen Couple**.....**\$50/Year**  
Covers two permanent family members residing together with one or both members over age 65.
- Couple**..... **\$60/Year**  
Covers two permanent family members residing together in the North Fork Valley.
- Family**..... **\$75/Year**  
Covers all permanent family members residing together in one household.

### North Fork Valley Business | Cover your business patrons, and employees!

- Business** ..... **\$100/Year**  
Business Membership covers owners and employees, as well as customers, on premise during normal business hours.

### Business Owner/Employee Discount

**\$10 Discount**

- I am the  Owner /  Employee of \_\_\_\_\_, a North Fork Valley based business that is a new/current **North Fork Ambulance Business Member**. As such, I qualify for a **\$10 discount** off my Membership total!

### Round-Up Your Membership?

Donations are utilized to purchase equipment, fund training and keep our EMTs ready to respond in emergencies. The North Fork Ambulance is a 501(c)(3) Non-Profit Corporation. Any donation to the Association is tax-deductible.

- \$25     \$50     \$75     \$100     \$\_\_\_\_\_

Please find my additional donation enclosed. \$\_\_\_\_\_

### Payment



**TOTAL AMOUNT INCLUDING DONATION ENCLOSED: \$ \_\_\_\_\_**

**Payment Method:** \_\_\_ Personal/Business Check    \_\_\_ Visa    \_\_\_ MasterCard    \_\_\_ Discover

**Credit Card #:** \_\_\_\_\_ **Name as it appears on Card:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_ **Card Security Code:** \_\_\_\_\_ **Billing Zip Code:** \_\_\_\_\_

**Signature of Card Holder:** \_\_\_\_\_ **Date Payment Made:** \_\_\_\_\_ **Check #** \_\_\_\_\_

**MAKE CHECKS PAYABLE TO: NORTH FORK AMBULANCE ASSOCIATION**

**Save time and postage! Sign up or renew your Membership online at [www.northforkambulance.com](http://www.northforkambulance.com)!**

**Application Continued on Back >**

**Primary Member |** Head of household or North Fork Valley business owner **- PLEASE PRINT LEGIBLY -**

Full LEGAL Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Email: \_\_\_\_\_  
REQUIRED FOR MEMBERSHIP CORRESPONDENCE

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: Colorado Zip: \_\_\_\_\_

Mailing Address (If Different): \_\_\_\_\_ City: \_\_\_\_\_ State: Colorado Zip: \_\_\_\_\_

**Business Member |** Business Owners - Complete the section below.

Business Owner Legal Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Business Name: \_\_\_\_\_ Number of Employees: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
REQUIRED FOR MEMBERSHIP CORRESPONDENCE

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: Colorado Zip: \_\_\_\_\_

Mailing Address (If Different): \_\_\_\_\_ City: \_\_\_\_\_ State: Colorado Zip: \_\_\_\_\_

**List Family Members Permanently Residing in Residence OR Business Employees Below**

*Permanent family members residing in your residence MUST be listed here to be covered!*

Full LEGAL Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Full LEGAL Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

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Full LEGAL Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**North Fork Ambulance Association Membership Program Agreement**

I represent that the information contained herein is true and accurate. I have read and agree with the terms of the *North Fork Ambulance Association Membership Program Agreement*. **I further understand and agree that my insurance company(ies) will be billed for payment in the event of services rendered.**

**To my insurance carrier(s) or other provider of medical benefits:**

- I authorize payment of benefits for emergency medical / ambulance transport service for myself or eligible family or business members directly to the North Fork Ambulance Association.

- I authorize and direct reimbursement for emergency medical/ambulance transport service pursuant to my policy(ies) to be sent directly to the North Fork Ambulance Association.

**Submission of this application with payment constitutes acceptance of the terms of the North Fork Ambulance Association Membership Program Agreement.**

Primary Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Upon approval of this North Fork Ambulance Association Membership Application, the foregoing shall become members in the North Fork Ambulance Association Membership Program as defined in the North Fork Ambulance Membership Program Agreement included with this application or available 24/7 on our website at [www.northforkambulance.com](http://www.northforkambulance.com).

**Membership coverage begins five (5) business days after acceptance of a properly completed application form with payment and extends for one (1) year from the date coverage begins.**

**Questions/Comments? Contact us.**

**North Fork Ambulance**

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