

NOGA AMBULANCE SERVICE INC.

20 10



**ANNUAL REQUEST
FOR MEMBERSHIP**

**INDIVIDUAL
\$30.00**

**FAMILY
\$40.00**

REVERSE SIDE MUST BE COMPLETED
TO ACTIVATE MEMBERSHIP

PLEASE
PRINT
NAME
AND
ADDRESS

Name _____
 Address _____
 City _____ State _____ Zip _____
 Township/Municipality _____

MAKE CHECK PAYABLE TO:
NOGA AMBULANCE SERVICE INC.

**INFORMATION CALLS ONLY:
(724) 652-8300**

**ALL EMERGENCY CALLS:
(724) 652-6677
(724) 752-1111**

MEMBER NAME: _____

**MEMBERSHIP
FEB. 1, 2010 TO JAN. 31, 2011**

TEAR HERE

2 0 1 0 S U B S C R I P T I O N R E Q U E S T

RETAIN THIS PORTION

**RETAIN THIS STUB FOR
YOUR RECORDS**



Amount Paid _____ Date Paid _____
 Check Number _____

AUTHORIZATION

I authorize that payment of authorized Medicare Benefits or other insurance benefits be made on my behalf for any services furnished by Noga Ambulance Service. I authorize any holder of medical information or documentation about me to release to the Health Care Finance Administration and its carrier and agents, as well as Noga Ambulance Service, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by Noga Ambulance Service now or in the future.

Signature _____ Date _____

List Family Members To Be Covered (Please Print)

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBERS

Phone No. _____