

**PENN YAN AREA VOLUNTEER AMBULANCE CORP., INC.**  
**AM-CORPS APPLICATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Property Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone # \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

**LIST SPOUSE, CHILDREN AND OTHER DEPENDENTS  
 CLAIMED FOR FEDERAL INCOME TAX**

| Last Name | First Name | MI | Date of Birth | Soc. Sec. # | Relationship |
|-----------|------------|----|---------------|-------------|--------------|
|           |            |    |               |             |              |
|           |            |    |               |             |              |
|           |            |    |               |             |              |

**INSURANCE INFORMATION**

MEMBER: Medicare # \_\_\_\_\_  
 BC/BS ID # \_\_\_\_\_  
 Other Insurance Name \_\_\_\_\_  
 Other Insurance ID # \_\_\_\_\_  
 Other Insurance Address \_\_\_\_\_

SPOUSE: Medicare # \_\_\_\_\_  
 BC/BS ID # \_\_\_\_\_  
 Other Insurance Name \_\_\_\_\_  
 Other Insurance ID # \_\_\_\_\_  
 Other Insurance Address \_\_\_\_\_

DEPENDENTS: Medicare # \_\_\_\_\_  
 BC/BS ID# \_\_\_\_\_  
 Other Insurance Name \_\_\_\_\_  
 Other Insurance ID# \_\_\_\_\_  
 Other Insurance Address \_\_\_\_\_

**MEDICAL AUTHORIZATION/ ASSIGNMENT OF BENEFITS**

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, Penn Yan Area Volunteer Ambulance Corps., Inc., or any insurance company, any information needed to determine Medicare benefits or the benefits payable for related services or any type of insurance claim, now and in the future. I permit a copy of this authorization to be used in place of the original, and request that payment available under an insurance be made directly to the Penn Yan Area Volunteer Ambulance Corps., Inc.

MEMBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SPOUSE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# PLEASE COMPLETE AND SIGN BOTH SIDES

## AM-CORPS AGREEMENT

I understand that AM-CORPS is not insurance or prepaid ambulance service. I also understand that my AM-CORPS annual subscription fee covers any deductible and/or amounts not paid by insurance for services rendered by the Penn Yan Area Volunteer Ambulance Corp, Inc. and/or Medic 55 during the time of my membership. I understand that my subscription fee will cover myself, spouse and any dependents as claimed for Federal Income Tax purposes living at the same address as outlined by the subscription classification I choose. I also understand and give my permission for the Penn Yan Area Volunteer Ambulance Corp., Inc. and/or Soldiers & Sailors Memorial Hospital to bill my insurance and to obtain benefits from my insurance carriers. I understand that the Penn Yan Area Volunteer Ambulance Corps., Inc. and Soldiers & Sailors Memorial Hospital will accept assignment of benefits from my insurance company and will bill my insurance company directly for me.

I understand that by billing directly, payment for my ambulance service should come to the Penn Yan Area Volunteer Ambulance Corp. or Soldiers & Sailors Memorial Hospital. I agree that should I receive payment from my insurance for services rendered by the Penn Yan Area Volunteer Ambulance Corp., Inc. or Soldiers & Sailors Memorial Hospital I will immediately forward this payment to the Penn Yan Area Volunteer Ambulance Corp., Inc. or Soldiers & Sailors Memorial Hospital.

Signed \_\_\_\_\_

### CHECK AM-CORP CLASSIFICATION

|   |          |
|---|----------|
| <input type="checkbox"/> I - Individual ..... | \$25.00  |
| <input type="checkbox"/> F - Family .....     | \$35.00  |
| <input type="checkbox"/> B - Business .....   | \$100.00 |

There is no additional charge for guest coverage.

Make check or money order payable to P.Y.A.V.A.C. and return to:

Penn Yan Area Volunteer Ambulance Corp., Inc.  
Corner of Main St. & North Ave.  
PO Box 272  
Penn Yan, NY 14527