MINQUAS FIRE COMPANY #2

Subscription Receipt

• 2025 •

You may complete this information for your records:

Date Sent _____ Amount $ _____ Check No. _____

Please refer to this number in any correspondence.

Thank you for your yearly support in our ambulance subscription membership program.

T005

001497

Please send in your subscription today!

KEEP THIS PORTION FOR YOUR RECORDS

ALL EMERGENCY CALLS:

9 - 1 - 1

INFORMATION CALLS ONLY:

610-269-2797

Detach Here

MINQUAS FIRE COMPANY #2

• 2025 •

Subscription Request

Circle the amount of your Subscription & Return this portion

Individual	Family	Senior Individual 65+ years of age	Senior Couple 65+ years of age	Additional Donation
$75.00	$110.00	$50.00	$65.00	$_____

Please refer to this number in any correspondence.

Make Checks Payable To:

MINQUAS FIRE COMPANY #2
141 WALLACE AVENUE
DOWNINGTOWN PA 19335

Please Make Any Necessary Corrections To Name & Address Below

3983
1

RETURN THIS PORTION IN THE ENVELOPE PROVIDED

Detach Here

MINQUAS FIRE COMPANY #2

Please detach this card after mailing us your subscription fee.

Please mail in your ambulance subscription promptly! Your support allows the Minquas Fire Co #2 to provide you and your family with efficient 24/7 9-1-1 service!

SUBSCRIPTION CARD

MINQUAS FIRE COMPANY #2
AMBULANCE MEMBERSHIP

EMERGENCY CALLS 9 - 1 - 1

ALL OTHER CALLS 610-269-2797

EXPIRES December 31, 2025

REMOVE AND RETAIN SUBSCRIPTION CARD

3983

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 or 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 family members residing at this address to be covered by this membership.	Date of Birth

Remember: Always wear your seatbelt and make sure children are properly secured.

This membership entitles the holder unlimited **Emergency Medical Service** within the coverage area, subject to the subscription terms and conditions available upon request.

— THANK YOU FOR YOUR SUPPORT —

8/04