LIFERIDE MONTHLY ENROLLMENT APPLICATION

I, ____ residing at
Participant

____
Address including ZIP

______________________________________ ______________________________________
Utility Account Number **Phone Number**

hereby elect to participate in the City of Broken Arrow's Emergency Medical Services Program known as LifeRide.

HOUSEHOLD RESIDENTS

1. ____ DOB:______________________
Name
Insurance:____________________________________ ID#:____________________Group#:_______

2. ____ DOB:______________________
Name
Insurance:____________________________________ ID#:____________________Group#:_______

3. ____ DOB:______________________
Name
Insurance:____________________________________ ID#:____________________Group#:_______

Please submit this completed application and send to:
LifeRide Program – PO Box 610 - Broken Arrow, OK 74013
For questions or additional information, please call: (918) 259-6595
or access the website at www.liferideba.org

As a resident of the aforementioned property, both me and those residing with me will receive program benefits. I understand that the City of Broken Arrow's LifeRide enrollment period lasts from August 1 – August 31 of each year. Membership in the program lasts from September 1 – August 31 of the following year. I further understand that the LifeRide Program does not include non-emergency transports or emergency medical services outside the City of Broken Arrow. I acknowledge that my insurance provider is responsible for payment of emergency services provided by the City of Broken Arrow. I acknowledge that it is my responsibility to provide the City with any valid insurance and third-party payer information, pertaining to me or anyone living in my household who received LifeRide services within sixty (60) days of the date of service. That failure to do so nullifies this agreement. In addition, I agree to furnish any information requested by my insurance company in order to facilitate payment of emergency medical services claims for me or anyone living in my household. In consideration for payment of the membership fee, I hereby assign the City all emergency medical service benefits that any covered family member or I may otherwise be entitled to receive from any insurance or other third-party payer for services provided under my LifeRide membership. The City will accept this assignment as payment in full for emergency transports, if insurance or other third-party payer coverage provides benefits for the transport. I understand that the City will file my emergency medical services insurance claims for each covered person and is entitled to receive payment from all insurance or other third-party payers up to the amount of the City's charges. If the enrolled has no insurance then I understand I will remain responsible for payment of the City's reduced fee for LifeRide members (40% off the entire emergency medical fee).

Signature:____________________________________ Dated:__________________________
I verify that this digital signature is my authorization of this form.