



CITY OF WEST COVINA FIRE DEPARTMENT  
MEMBERSHIP RENEWAL

Your subscription expires soon. Renewal payments must be received prior to the expiration date to avoid any lapse in benefits. Avoid any interruption of service by completing this renewal and mailing to the address below. Please include payment of \$73.49 per Household. Return the form along with a copy of your medical insurance card(s) and fee *payable* to:

City of West Covina Fire Department  
P.O. Box 269110  
Sacramento, CA 95826

Renewal will be declined if form is incomplete or payment amount is incorrect.

You will receive paramedic ambulance service as often as medically necessary. Members of our program will enjoy full coverage, without having to pay any out-of-pocket expenses for ambulance service. One single trip will more than save the cost of the annual membership

**RENEWAL**

I, HEREBY, RENEW MY MEMBERSHIP in the City of West Covina Fire Department's Ambulance Membership Program as (check one)  an Individual or a  Family.

**Method of Payment: (Payable to City of West Covina Fire Department)**

Check  Money Order

**Application Instructions:**

1. Each applicant must fill out all information.
2. Each applicant must provide a copy of all insurance cards, including Medicare, Medicaid and any primary and secondary insurance carriers. Copies should include both the front and back of the card.
3. Be sure to include payment in the envelope with your completed and signed application.
4. Please mail the entire application form.
5. If there are not enough spaces for all family members of the household, please us another piece of paper and add the applicants' complete information.

All terms and conditions agreed upon in my/our signed original Membership Application remain in full effect with this renewal.

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Signature of Primary Applicant

FOR QUESTIONS OR IF MORE INFORMATION IS NEEDED PLEASE CALL 1-800-906-6552



<b>Head of household</b>			
Last Name	First Name	Sex	M <input type="checkbox"/> F <input type="checkbox"/>
Mailing Address			
City, State, Zip Code			
Home Phone #	Date of Birth		
Social Security #	Medicare #		
Insurance Company Name			
Insurance Company Address			
Insurance Company Phone #			
Policy or I.D. #	Group #		
Name of Insured Policyholder:	Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Other <input type="checkbox"/>

<input type="checkbox"/> <b>child</b> <input type="checkbox"/> <b>dependent</b> <input type="checkbox"/> <b>other</b>			
Last Name	First Name	Sex	M <input type="checkbox"/> F <input type="checkbox"/>
Mailing Address			
City, State, Zip Code			
Home Phone #	Date of Birth		
Social Security #	Medicare #		
Insurance Company Name			
Insurance Company Address			
Insurance Company Phone #			
Policy or I.D. #	Group #		
Name of Insured Policyholder:	Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Other <input type="checkbox"/>

<input type="checkbox"/> <b>spouse</b> <input type="checkbox"/> <b>other</b>			
Last Name	First Name	Sex	M <input type="checkbox"/> F <input type="checkbox"/>
Mailing Address			
City, State, Zip Code			
Home Phone #	Date of Birth		
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Insurance Company Phone #			
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Name of Insured Policyholder:	Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Other <input type="checkbox"/>

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