



LONGWOOD FIRE COMPANY

Emergency Medical Services

1001 East Baltimore Pike • Kennett Square, PA 19348

NONPROFIT
ORGANIZATION
U.S. Postage
PAID
Permit No. 41
Media, PA

I have proofread this copy & accept all responsibility for any errors, omissions, etc. once the following corrections have been made as indicated.
Name _____ Date _____

10/28/15



2016
Annual Subscription Drive

January 1, 2016 to December 31, 2016

Subscription valid from above dates.

Why should you contribute?

Ambulance Service is not Free:

The funds we receive from the municipalities do not cover the costs needed to provide training, equipment, emergency vehicles, supplies, and operating costs needed by our paid and volunteer EMS professionals.

Ambulance Service is Expensive:

With charges starting at \$1200, they can increase to over \$1,800, depending on the service provided. More insurance companies are requiring Co-Pays, and less are covering the services in full.

If you should require emergency ambulance service, we will respond, regardless of whether you donate. Those who choose not to contribute will be responsible for any amount not paid by their insurance company.

Make checks payable to:

LONGWOOD FIRE COMPANY

1001 East Baltimore Pike
Kennett Square, PA 19348



LONGWOOD FIRE COMPANY

Emergency Medical Services

Subscription Expires December 31, 2016

REFERENCE NO. ➤

Business Office: (610) 388-6880 • Emergency: Dial 9-1-1
ambulanceclub@longwoodfireco.com

Retain This Card For Your Records

THANK YOU FOR YOUR CONTRIBUTION!

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Detach and return this portion with your donation.

LONGWOOD FIRE COMPANY Emergency Medical Service

Please check amount of contribution in boxes below:

Single
☐ \$50.00

Household
☐ \$100.00

Additional Tax
Deductible Donation
☐ \$ _____

Make checks payable to Longwood Fire Company

2016

Annual Subscription Drive

Visit our secure website to use:

PayPal

www.Longwoodfireco.com

Information Calls: (610) 388-6880
ambulanceclub@longwoodfireco.com

Please complete form on reverse side ➔

Reference No.

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Kindly change name/address as indicated above.

AUTHORIZATION

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

Name: _____ Phone: _____ Email: _____

Member Information: ☐ Single ☐ Married Number of Residents in House _____ Current Date _____



Please list all family members residing at this address to be covered by this membership.

Date of Birth

Medicare
Yes / No

Yes / No

Yes / No

Yes / No

Yes / No

Yes / No

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