

Detach and keep this part for your records. Return the other part with your remittance to:

**Camp Hill
Fire Company - EMS
P.O. Box 633
Camp Hill, PA
17001-0633**

Other members of family to be covered within household:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

AUTHORIZATION

I request that payment of any authorized insurance benefits be made either to me or in my behalf to Camp Hill Fire Company - EMS and/or West Shore ALS for any services furnished by this health service provider or supplier. I authorize any holder of medical information about me to release to our agents any information needed to determine these benefits payable to related services.

Head of household to sign where indicated on reverse side.