CHAL-BRIT REGIONAL
Emergency Medical Services
A Division of Chalfont EMS

NONPROFIT ORGANIZATION
U.S. Postage
PAID
PERMIT #7477
PHILADELPHIA, PA

P.O. Box 506 • Chalfont, PA 18914

Information Calls: 215-822-1308 ext. 418

www.ChalfontEMS.org

SUBSCRIPTION DRIVE
June 1st 2024 - June 30th 2025
MEMBERSHIP MAKES A DIFFERENCE
Help us during our annual subscription going on now thru June 30th, 2025

Dear Neighbor,

This year, more than ever, we are asking you to **HELP US…HELP YOU**. We have had to replace 3 ambulances in the last few years so funds have been tight. You not only support Chal-Brit Regional EMS by becoming a subscription member, but you could also save money if you need help in an emergency. As a subscriber, all fees charged by Chal-Brit Regional EMS for 911 emergency ambulance services that are over and above those paid by your insurance, would be covered by your subscription. Non-subscribers will be responsible for paying the balance that is not covered by their insurance. Many insurance plans do not cover the full cost of our service, which can range from $900.00 to $1,700.00 depending on the severity of the emergency.

Chal-Brit Regional EMS is a non-profit incorporation, organized under section 501(c)(3) of the Internal Revenue Service and we're able to accept tax-deductible contributions. Specific questions regarding the tax deductibility of subscription payments are best answered by your accountant. Additional contributions above your subscription are tax-deductible and are greatly appreciated!!

The support of our community is essential in keeping **YOUR** Ambulance Squad a community based non-profit organization.

The members at Chal-Brit Regional EMS sincerely Thank-You for your past generosity and continued support.

Sincerely,

The Officers and Members of Chal-Brit Regional EMS

For questions
call (215) 822-1308

The official registration and financial information of Chalfont Emergency Medical Service may be obtained from the Pennsylvania Department of State by calling toll free within Pennsylvania. 1(800) 732-0999. Registration does not imply endorsement.

We now offer five levels of Subscription Membership

Family Plus: Covers all adults and children that reside in the household.

Family: Covers up to 2 adults and all children under 18 years old in the household.

Individual: Covers 1 adult.

Senior Family: Covers 2 adults in a household (at least 1 adult must be 65+).

Senior Individual: Covers 1 adult (65+).

PLEASE NOTE: Any and all monies received by the subscriber from their insurance company for services provided by Chal-Brit Regional EMS, must be paid to Chal-Brit Regional EMS. Failure to do so will result in the immediate termination of any subscription agreement and you will be held responsible for payment of all outstanding balances.

Reference No.

CHAL-BRIT REGIONAL
Emergency Medical Services

2024-2025

Name:_____

$_____
AMOUNT

Thank you for your tax free contribution!

EMERGENCIES: DIAL 9-1-1

Detach and return this portion with your donation.

CHAL-BRIT REGIONAL *Emergency Medical Services* **DONATION FORM**

2024-2025 Donation Rates:

- ☐ Individual Rate $50.00
- ☐ Family Membership Rate $70.00
- ☐ Family Plus Membership Rate $80.00
- ☐ Senior Individual Rate (65 & Over) $40.00
- ☐ Senior Family Rate (65 & Over) $55.00
- ☐ Additional Tax-Deductible Donation ..... $_____

PLEASE COMPLETE AND RETURN THIS PORTION.

For payments via PayPal, please include your reference number and membership type

Visit our secure website to use:

PayPal VISA MasterCard DISCOVER AMERICAN EXPRESS

www.ChalfontEMS.org

Please make checks payable to:
Chal-Brit Regional EMS

Reference No.

CHAL-BRIT REGIONAL EMS
C/O AMERICAN HERITAGE FED CREDIT
765 EAST BUTLER PIKE
NEW BRITAIN PA 18901-5307

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Kindly change name/address as indicated above.

CHAL-BRIT REGIONAL

Emergency Medical Services

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For additional information, call

(215) 822-1308

Thank You For Your Support.

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.

Signature _____ Phone Number _____ 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.