

StarSaver Application Information and Instructions

Application Instructions

Please print clearly or type all information, sign and return with your payment.

- Each applicant must fill out all information
- Each applicant, age 18 and over, must sign application. By signing the application, you acknowledge that you have read and understand the agreement and agree to the terms of the entire agreement.**
- Be sure to include your payment in envelope with your completed, signed application.
- Please DO NOT cut or tear application apart. Fold in thirds and place in the attached envelope with your payment.
- If there are not enough spaces for all members of your household, please use another piece of paper and write the applicant's complete information.

MedStar is compliant with HIPAA regulations. A copy of our Notice of Privacy Practices is available on request, or you may visit our website at www.medstar911.org

Head of Household New Renewal

Are Eligible for Medicaid? Yes No

Last Name _____ First Name _____ Male Female

Mailing Address _____

City, State Zip Code _____

Home Phone _____ Date of Birth _____

Email _____

Social Security Number _____ Medicare Number _____

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone _____

Policy or I.D. Number _____ Group Number _____

Insurance Carried Through (Employer, Union, etc.) Retired Yes No

Name of Insured Policyholder: Self Spouse Other

Signature (Head of Household)

Spouse Other

Are Eligible for Medicaid? Yes No

Last Name _____ First Name _____ Male Female

Home Phone _____ Date of Birth _____

Social Security Number _____ Medicare Number _____

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone _____

Policy or I.D. Number _____ Group Number _____

Insurance Carried Through (Employer, Union, etc.) Retired Yes No

Name of Insured Policyholder: Self Spouse Other

Signature (Spouse/Other)

Other Child Dependent Other

Are Eligible for Medicaid? Yes No

Last Name _____ First Name _____ Male Female

Home Phone _____ Date of Birth _____

Social Security Number _____ Medicare Number _____

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone _____

Policy or I.D. Number _____ Group Number _____

Insurance Carried Through (Employer, Union, etc.) Retired Yes No

Name of Insured Policyholder: Self Spouse Other

Signature (Child/Dependent/Other)

Other Child Dependent Other

Are Eligible for Medicaid? Yes No

Last Name _____ First Name _____ Male Female

Home Phone _____ Date of Birth _____

Social Security Number _____ Medicare Number _____

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone _____

Policy or I.D. Number _____ Group Number _____

Insurance Carried Through (Employer, Union, etc.) Retired Yes No

Name of Insured Policyholder: Self Spouse Other

Signature (Child/Dependent/Other)

Other Child Dependent Other

Are Eligible for Medicaid? Yes No

Last Name _____ First Name _____ Male Female

Home Phone _____ Date of Birth _____

Social Security Number _____ Medicare Number _____

Insurance Company Name _____

Insurance Company Address _____

Insurance Company Phone _____

Policy or I.D. Number _____ Group Number _____

Insurance Carried Through (Employer, Union, etc.) Retired Yes No

Name of Insured Policyholder: Self Spouse Other

Signature (Child/Dependent/Other)

Method of Payment

Check Money Order (Payable to MedStar StarSaver)

VISA MasterCard Discover

Health Savings Account

Debit or Credit Card #

Expiration Date / Card Code

(The three numbers printed on the back of your credit card)

Cardholder Information

Signature _____

Address _____

City, State Zip code _____

Health Savings Account _____

Card # _____

Survey Information

How did you hear about the StarSaver membership?

Mail Friend/Neighbor Newspaper

Presentation Paramedics Billing Office

Other _____

Please add a separate sheet for other household members if necessary