

**Platinum Protection Program
Applicant Information**

Rec'd	_____
Medicaid:	_____
Completed:	_____

HOH Name: _____
Address: _____
City/ State/ Zip: _____
Phone: _____
Pertinent Med History: _____
Allergies: _____
Date of Birth: _____
Social Security: _____
Primary Insurance: _____
Policy/ Group _____
Address: _____
City/ State/ Zip: _____
Secondary Insurance: _____
Policy/ Group _____
Address: _____
City/ State/ Zip: _____

Spouse or Dependent of HOH (Under 21 years of Age)

Name: _____
Address: _____
City/ State/ Zip: _____
Phone: _____
Pertinent Med History: _____
Allergies: _____
Date of Birth: _____
Social Security: _____
Primary Insurance: _____
Policy/ Group _____
Address: _____
City/ State/ Zip: _____
Secondary Insurance: _____
Policy/ Group _____
Address: _____
City/ State/ Zip: _____

Attach if more than one dependent

Directions to Residence: _____

Nearest Intersection: _____

Print and mail application with payment to: Platinum Protection Plan
STAT CARE EMS
P.O. Box 552
Beaumont, Texas 77704-0552