The Friends Foundation
♥ Application for Philips Lifeline Medical Alert Service ♥

Name _____ DOB ___/___/ _____

Physical Address _____

Mailing Address _____

City _____ Zip _____ Phone # _____

Email: _____

Type of Phone: Land Line (___) Cell Phone (___)

Physician _____ Phone # _____

EMERGENCY CONTACT INFORMATION

Contact Name _____

Relationship _____

Address _____

City _____ Zip _____ Phone 1: _____

Phone 2: _____ Email: _____

I certify that the information above is true and correct to the best of my knowledge. I understand that I am applying for Philips Lifeline Medical Alert equipment, to be leased by The Friends Foundation on my behalf, and The Friends Foundation agrees to pay monthly cost for **Basic Service** to lease the equipment. If any optional equipment is needed, such as a device with Automatic Fall Alert or a GPS unit for coverage away from home, a $15 monthly Co-pay which can be paid quarterly $45 or annually $180, is required. If my family or I cannot afford the monthly Co-pay charge, I understand I may complete and submit an application to The Friends Foundation for Financial Assistance. I also agree and understand that The Friends Foundation must be notified when the equipment is no longer needed, and that I will be billed for the $400 fee charged by Philips Lifeline ($500 for wireless equipment or if connected via a mobile phone), if the equipment is not returned to The Friends Foundation.

Applicant Signature _____ Date _____

Installer notes: revised: 08122020