HEALTH INSURANCE INFORMATION

Your Name _____Date of Birth_____

Insured's Name _____ Date of Birth_____

Relationship to Insured_____

Employer

_____

Primary Insurance Company Name

_____

Insurance Company Address

_____

Insurance Company Phone Number _____

Insured's ID Number _____

Insured's Policy Group_____

Insured's Plan Name _____

Deductible amount_____Co-payment amount (if any) $_____

Secondary Insurance Company Name (if any)

_____

Company Address

_____

Company Phone Number _____

Insured's ID Number _____

Insured's Policy Group_____

Insured's Plan Name _____

Deductible amount_____Co-payment amount (if any) $_____