HEALTH INSURANCE INFORMATION SHEET

EVERY PARTICIPANT MUST HAVE THIS FORM ON FILE

Private insurance information must be provided, if applicable. If a participant does not have private health insurance, please be advised that, should a participant require medical attention, you are responsible for paying any costs not covered by insurance.

Participant's Name _____ Participant's SS Number _____

Participant's Address

City _____ State _____ Zip _____

Participant's Phone Number _____ Date of Birth _____

Insurance Company _____ Effective Date _____

Insurance Company Address _____

Insurance Company Phone Number _____ Group # _____

Policyholder's Name _____ Policy # _____

Policy Holder's Address _____

Relationship to Participant _____

Contact Number _____ Employee Number _____

Name of Primary Care Physician _____

PCP Phone Number _____

I hereby authorize the release of any medical information which might be needed in connection with payment for medical services.

Participant Signature _____ Date _____

Parent/Guardian Signature: _____ Date _____

I request that payment under my medical insurance program be made directly to the provider on any bills for services rendered by that provider. I understand that I am financially responsible for fees not covered by this authorization.

Participant Signature _____ Date _____

Parent/Guardian Signature _____ Date _____