

Account No. \_\_\_\_\_

Date \_\_\_\_\_

Patient \_\_\_\_\_

**PRIMARY INSURANCE COMPANY**

Name of Insurance Co.	Policy ID No.	Group No.
Street Address	City	State Zip
Name of Policy Holder	Social Security No.	Relationship to Insured
Policy Holder's Address		
Policy Holder's Date of Birth	Policy Holder's Employer	

**SECONDARY INSURANCE COMPANY**

Name of Insurance Co.	Policy ID No.	Group No.
Street Address	City	State Zip
Name of Policy Holder	Social Security No.	Relationship to Insured
Policy Holder's Address		
Policy Holder's Date of Birth	Policy Holder's Employer	

**Disclosure of any other health benefit plans:**

Name of Insurance Co.	Policy ID No.	Group No.
Street Address	City	State Zip
Name of Policy Holder	Social Security No.	Relationship to Insured
Policy Holder's Address		
Policy Holder's Date of Birth	Policy Holder's Employer	

I certify that the information I have reported with regard to my health insurance plan(s) is correct.

\_\_\_\_\_  
 Signature of Insured or Authorized Person

\_\_\_\_\_  
 Date