



Employee/Policyholder Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Patient name: \_\_\_\_\_

Relationship: \_\_\_\_\_

- A.  Y  N Is patient employed?  
B.  Y  N Is there an employer sponsored health care plan offered by that employer to the patient?  
C.  Y  N Has the patient been enrolled under any other health care plan within the past year? \*

*\* If another plan enrollment is active or has terminated within the past year, we need the plan information below.*

Effective date of coverage: \_\_\_\_\_ Termination date (if applicable): \_\_\_\_\_

Employer name (if applicable) \_\_\_\_\_ Phone: \_\_\_\_\_

Health care plan: \_\_\_\_\_

Address: \_\_\_\_\_

Policy/Plan number: \_\_\_\_\_ Policyholder: \_\_\_\_\_

Policyholder Date of Birth: \_\_\_\_\_

Level of coverage:  IND  EE/Spouse  EE/Child(ren)  Family

Benefits:  Medical  Dental  Vision

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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