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:_____

Level of coverage: ( ) IND ( ) EE/Spouse ( ) EE/Child(ren) ( ) Family
Benefits: ( )Medical ( )Dental ( ) Vision

Employee Signature: _____ Date: _____

Phone Number: _____

FAX to: 302-629-8416

110 South Shipley Street Seaford DE 19973 800-959-3518 www.integratpa.com