



PLEASE TYPE OR PRINT

Participant Information:

Last Name _____ First Name _____ Initial _____

Date of birth _____ Social Security Number _____

Mailing Address _____

City _____ State _____ Zip _____

Is Member covered by any other insurance? Yes No

If so, please complete the information below

Name of insurance company _____ Phone number _____

Policy Number _____ Group Number _____ ID Number _____

Type of plan: Medical Prescription Dental Vision

Is this coverage through an employer? Yes No

If yes, list employer _____

Dependent Information:

Name (first and last)	Relationship to Policyholder	Date of Birth	Covered by other insurance?	Name of Carrier
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____

If single, divorced, separated, or remarried with children

(Complete this section even if it duplicates information reported above)

Individual responsible for children's coverage _____

Name _____ Relationship to child _____

Mailing Address _____

City _____ State _____ Zip _____

Date of birth _____ Social Security Number _____

Name of Health Insurance providing child's coverage _____

Policy Number _____ Group Number _____ ID Number _____

Effective date of coverage _____ Type of plan: Medical Prescription Dental Vision

Children's names (first and last)	Who has custody?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____



Medicare Coverage

List family members covered by Medicare:

Name (first and last)	Medicare number
1. _____	_____
2. _____	_____

Check the type of Medicare coverage and the effective date (indicated on the Medicare card)

___ Medicare (Basis of age) Effective Date: _____

___ Medicare Disability (Basis of Disability) Effective Date: _____

___ ESRD Entitlement (Permanent Kidney Failure) Effective Date: _____

Member Name: _____

I have answered all questions truthfully and to the best of my knowledge.

Signature of Member: _____

Date: _____

Please provide a copy of the other medical, prescription, dental, vision, or Medicare card.