



Date: _____

ID Number: _____

SECTION I Do you or a family member have another Health Insurance policy? ▶		YES <input type="checkbox"/> NO <input type="checkbox"/>
HEALTH INSURANCE COMPANY INFORMATION: ▼	NUMBER OF PEOPLE COVERED	
Name:	CHECK ONLY ONE ▼	
Address:	<input type="checkbox"/> 1. ONE PERSON - POLICYHOLDER	
Phone #:	<input type="checkbox"/> 2. TWO PERSON – POLICYHOLDER AND SPOUSE/PARTY TO CIVIL UNION	
Policy #:	<input type="checkbox"/> 3. TWO PERSON – POLICYHOLDER AND CHILD ONLY	
Group #:	<input type="checkbox"/> 4. FAMILY – THREE OR MORE	
Effective Date:	Policy Holder Name:	

SECTION II Do you or a family member have a Dental Insurance policy? ▶		YES <input type="checkbox"/> NO <input type="checkbox"/>
DENTAL INSURANCE COMPANY INFORMATION: ▼	NUMBER OF PEOPLE COVERED	
Name:	CHECK ONLY ONE ▼	
Address:	<input type="checkbox"/> 1. ONE PERSON - POLICYHOLDER	
Phone #:	<input type="checkbox"/> 2. TWO PERSON – POLICYHOLDER AND SPOUSE/PARTY TO CIVIL UNION	
Policy #:	<input type="checkbox"/> 3. TWO PERSON – POLICYHOLDER AND CHILD ONLY	
Group #:	<input type="checkbox"/> 4. FAMILY – THREE OR MORE	
Effective Date:	Policy Holder Name:	

SECTION III Do you or a family member have Medicare Insurance? ▶		YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you have Medicare part <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D		
MEDICARE INSURANCE INFORMATION: ▼		
Policyholder Name:	Medicare Part A Effective Date:	
Medicare ID #:	Medicare Part B Effective Date:	
	Medicare Part D Effective Date:	

Signature: _____ Date: _____ Phone #: _____