POLICY or CLAIM NUMBER
1 5 2 3 1 2

NAME OF EMPLOYER
SERVICE COMPANY

ADDRESS
5514 TEST STREET

CITY
TALO

STATE
MI

ZIP
11224 -

NAME OF ATTORNEY / REPRESENTATIVE

ADDRESS

ADDRESS

CITY

STATE

ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY:
BROKEN FINGER

PART III - INFORMATION ABOUT YOUR SPOUSE/OTHER FAMILY MEMBER

1) Do you have any group health plan coverage based upon your spouse's/other family member's current employment? **YES** ☐ **NO** ☒ If no, sign on the bottom of the form.

2) How many employees, including your spouse, work for the employer from whom you have health insurance?
1-99 ☐ **100 or more** ☐

Please print the name of the spouse's/other family member's current employer, and information about the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

CITY

STATE

ZIP

NAME OF HEALTH PLAN

ADDRESS

ADDRESS

CITY

STATE

ZIP

DATE INSURANCE COVERAGE BEGAN
M M – D D – Y Y Y Y

POLICY NUMBER

POLICY HOLDER/SUBSCRIBER'S NAME

RELATIONSHIP

TYPE OF INSURANCE: HOSPITAL AND MEDICAL ☐ HOSPITAL ONLY ☐ MEDICAL ONLY ☐

Your Signature John Q. Public

AREA CODE **PHONE NUMBER**
555 - 555 - 5555

OMB # 0938-0214 MSP12