HEALTH INSURANCE AUTHORIZATION

Insurance Information (PLEASE PRINT)

Name _____ Date of birth _____

Address _____

City _____ State _____ Zip Code _____

Name of primary insured _____

Date of birth of primary insured _____

Address of primary insured (if different than client) _____

City _____ State _____ Zip Code _____

Primary Insured Place of Employment: _____

Primary Insurance Company _____

ID # _____ Group # _____