POLICY or CLAIM NUMBER

NAME OF EMPLOYER

ADDRESS

CITY | STATE | ZIP -

NAME OF ATTORNEY / REPRESENTATIVE

ADDRESS

ADDRESS

CITY | STATE | ZIP -

BRIEF DESCRIPTION OF ILLNESS OR INJURY:

PART III - INFORMATION ABOUT YOUR SPOUSE

1) Do you have any group health plan coverage based upon their spouse'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?
1-19 ☐ **20 or more** ☒

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

EMPLOYER NAME
ABC COMPANY

ADDRESS
3 TEST DRIVE

CITY
SAMPLE | STATE OH | ZIP 2 1 1 1 1 1 -

NAME OF HEALTH PLAN
GOOD HEALTH INC.

ADDRESS
6 VEGGIE WAY

ADDRESS

CITY
SAMPLE | STATE OH | ZIP 2 1 1 1 1 1 -

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

POLICY NUMBER

POLICY HOLDER/SUBSCRIBER'S NAME
JANE E PUBLIC

RELATIONSHIP
SPOUSE

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

Your Signature John Q. Public

AREA CODE **PHONE NUMBER**
000 – 1111 – 2222

OMB # 0938-0214 MSP08