SECONDARY INSURANCE COVERAGE

INSURANCE CARRIER COMPANY NAME: _____

INSURANCE CARRIER ADDRESS:_____

INSURANCE CARRIER CITY, STATE, ZIP:_____

CONTACT NAME/CONTACT PHONE:_____

EMPLOYER INFORMATION

EMPLOYER COMPANY NAME:_____

EMPLOYER ADDRESS:_____

EMPLOYER CITY, STATE, ZIP:_____

CONTACT NAME/CONTACT PHONE:_____

GROUP NUMBER:_____

INSURANCE PLAN ID:_____
(If employer has more than one insurance plan)

PLANT LOCATION:_____

SUSCRIBER INFORMATION

NAME_____
(Last, First, Middle Initial)

BIRTHDATE_____
(Month, Date, Year)

EMPLOYMENT STATUS _____ACTIVE _____INACTIVE _____RETIRED

SOCIAL SECURITY NUMBER: _____-_____-_____

PATIENT RELATIONSHIP TO SUBSCRIBER: _____SON _____DAUGHTER _____SELF

_____SPOUSE _____OTHER

PATIENT NAME:_____
(Last, First, Middle Initial)

I hereby authorize payment directly to William P. Swetlik, D.D.S., S.C. of the group insurance benefits otherwise payable to me.

_____
(Insured's Signature)