

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 Shawano Orthodontics of the group insurance benefits otherwise payable to me.

(Insured's Signature)