NAME OF EMPLOYER

ADDRESS

CITY STATE ZIP -

NAME OF ATTORNEY / REPRESENTATIVE

ADDRESS

ADDRESS

CITY STATE ZIP -

BRIEF DESCRIPTION OF ILLNESS OR INJURY:

BROKEN ARM LEFT SIDE

NECK PAIN

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 or former employment? **YES** ☐ **NO** ☒ If no, sign on the bottom of the form.

Please print the name of the spouse's/other family member's current or former 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 000 - **PHONE NUMBER** 1111 - 2222

OMB # 0938-0214 MSP10