Insurance Information:

Primary Insurance Carrier: _____

ID#: _____ Group #: _____

Address to submit the claim:

_____

Street City State Zip Code _____

Policy Holder's Name: _____

SS#: _____

Date of Birth: ____/____/____ Relationship to Child: _____

Employer Name: _____

Secondary Insurance Carrier: _____

ID#: _____ Group #: _____

Address to submit the claim:

_____

Street City State Zip Code _____

Policy Holder's Name: _____

SS#: _____

Date of Birth: ____/____/____ Relationship to Child: _____

Employer Name: _____

I DO NOT HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAT THE ABOVE MENTIONED. Initial _____