PO Box 900
Lincroft, NJ 07738

High Point Preferred Insurance Company
High Point Safety and Insurance Company
High Point Property and Casualty Insurance Company
Palisades Safety and Insurance Association
Palisades Insurance Company
Palisades Property and Casualty Insurance Company

HEALTH CARRIER INFORMATION FORM

Claim Number:

Patients Name (Your Name): First Name Last Name

Plan Holders Name: ____

Plan Holders Employer and Address: ____________________________________

Primary Health Carrier Name: _______________________________________

How long have you had your current Health Carrier (# of months / # of years):_______

Health Carrier Group#:______________________________________

Health Carrier Tele#: ____

Secondary Health Carrier Name: ______________________________________

How long have you had your current Health Carrier (# of months / # of years):_______

Health Carrier Group#:______________________________________

Health Carrier Tele#: ____

PLEASE ENCLOSE THE FOLLOWING:
(Photocopy) of your Health Carrier Card (front & back)
(Photocopy) of your Health Carrier's Summary Plan Description

I hereby authorize ______________________ as my Health Care Carrier, to release a copy of the Summary Plan Documents and Master Plan to Plymouth Rock Management Company of New Jersey.

_____________________________ _________________
Signed (Patient) Date

____________________________ ________________
Signed (Plan Holder) Date

***The information requested is necessary to verify that your Health Carrier Plan will accept medical bills as the primary insurance.**