Twin Lights INSURANCE

PO Box 923
Lincroft, NJ 07738

Underwritten by
Twin Lights 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.**