

OTHER INSURANCE INFORMATION

Spouse/Dependent employed by _____
(PLACE, NAME AND ADDRESS ABOVE)

Do you or your spouse/dependent have other group health care coverage? yes no

If "yes," name of insurance company _____ policy no. _____

LIST SPOUSE AND ALL ELIGIBLE CHILDREN BELOW:

First	NAME		Social Security No.	Birth Date	Relationship
	Initial	Last (if different than employee)			

AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the above information is true and correct to the best of my knowledge. I hereby authorize the Plan Administrator, any physician, medical practitioner, pharmacist, or other person, any hospital, including Veterans Administration or government hospital, any medical or medically-related facility, any pharmacy, any insurance company or any other agent of the Plan to release to each other any medical or other information relating to claims for benefits from the Plan. A photostat of this authorization shall be valid as the original.



employee's signature

date

