

Island Group Administration, Inc. □
3 Toilsome Lane □
East Hampton, NY 11937 □
Phone: 631-324-2306 Fax: 631-324-7021 |
www.islandgroupadmin.com

Verification of Current Insurance Information

Please answer all questions and return the signed and dated questionnaire to Island Group Administration at the above address. Thank You. Your claims will be promptly considered upon return of this completed and signed questionnaire. **PLEASE PRINT or TYPE IN BLACK OR BLUE INK.**

Member name: _____

Member number: _____

Are you covered under any medical insurance plan ? _____

If yes, name of insurance co: _____ Tel # of insurance co: _____

Policy # _____ Group # _____ Group/Plan Name (Name of Employer) _____

Employer Tel # _____ Number of persons working for your employer _____

Type of plan: Active Ret. COBRA Medicare Part A Medicare Part B

Medicare Disability Medicare Kidney Disease Medicaid

Coverage type: Family Individual Is coverage: Medical Dental Medical & Dental

Effective date: _____ Termination date, if applicable: _____

Is your spouse covered under any medical insurance plan other than Island Group _____

If yes, name of insurance co: _____ Tel # of insurance co: _____

Policy # _____ Group # _____ Group/Plan Name (Name of Employer) _____

Employer Tel # _____ Number of persons working for spouse's employer _____

Type of plan: Active Ret. COBRA Medicare Part A Medicare Part B

Medicare Disability Medicare Kidney Disease Medicaid

Coverage type: Family Individual Is coverage: Medical Dental Medical & Dental

Effective date: _____ Termination date, if applicable: _____

Spouse's date of birth _____ Spouse's SS# _____

Are any eligible dependent children, as defined in your subscriber agreement, covered under your spouse's medical plan? _____

If yes, please list names, dates of birth and social security numbers:

Name	DOB	SS#
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_____	_____	_____
_____	_____	_____
_____	_____	_____

In case of divorce:

Name of person with custody of child: _____

Relationship to child: _____ Does this person provide insurance for the child? _____

If the divorce decree indicates which parent is responsible for providing the child with insurance coverage, specify the name of parent: _____

I hereby attest that the information provided above is true and accurate.

Subscriber's Signature (or signature of legal guardian)

Date