

Medical Reimbursement Program

SPOUSAL INSURANCE INFORMATION

1. Employee Name _____ Social Security Number _____ Date of birth _____

Home phone number _____

2. Spouse name _____ Social Security Number _____ Date of birth _____

3. Is spouse employed _____ If yes, name of employer _____
phone number _____

4. Does spouse's employer offer health insurance _____

Name of insurance company _____ Policy number _____

5. Who is covered by spouse's employer's health insurance plan: (please check appropriate boxes)

No one Spouse eff. date _____ You eff. date _____

Dependent children

Name _____ DOB _____ eff. date _____

Name _____ DOB _____ eff. date _____

Name _____ DOB _____ eff. date _____

Name _____ DOB _____ eff. date _____

Name _____ DOB _____ eff. date _____

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical facility, attorney, insurance company, or other involved entity to disclose to Employee Benefit Concepts, Inc. and their authorized representatives: information regarding diagnosis, treatment, and prognosis, pertaining to medical history and physical or mental condition, and payments billed or received, in regard to the above Insureds. I understand that the information so acquired will be used to evaluate my claim for insurance benefits. A photographic copy of this authorization will be as valid as the original.

Employee's Signature _____

Date _____

Spouse's Signature _____

Date _____

Please mail or fax this sheet to :

**Employee Benefit Concepts, Inc.
PO Box 515
Cuyahoga Falls OH 44222
Fax 330-923-1933
phone 1-800-247-3711**