Eligibility Waiver Form

Please complete all boxes and blanks spaces. Thank You

Subscriber Last Name	First Name	M.I
Patient Last Name	First Name	M.I
Member I.D #	Group #	Health Plan

I, _____, understand that I am eligible for
(Name of the patient)
_____ benefits on or as of _____
(Health Plan) (Effective Date)

through my _____employment at _____.
(Own, Spouse's, Parent's) (Name of Employer)

I understand that_____ is my selected group
(Name of Group)
under which I am covered. I am aware that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially for me) will pay in full such charges.

x_____ _____

Signature of patient or responsible party Date