HERITAGE CONSULTANTS / PROFESSIONAL ADMINISTRATORS

INSTRUCTIONS TO EMPLOYEE

- Complete in full for yourself and all dependents.
- Sign and date all areas at the bottom of the form.
- Mail completed form to:

Heritage Consultants/Professional Administrators
P.O. Box 1730
Auburndale, FL 33823

Employed By (Your Company's Name)			
Employee Name	Employee's Soc. Sec. No.	D.O.B.	Sex ❑ M ❑ F
Mailing Address	City	State	Zip
Telephone Numbers Home: ( ) Work: ( )	Is Employee covered by Medicare? ❑ YES ❑ NO If Yes, please submit a copy of your Medicare ID card.	Marital Status ❑ Single ❑ Separated Date_____ ❑ Married ❑ Divorced Date_____ ❑ Widowed	

SPOUSE INFORMATION (TO BE COMPLETED IN FULL)

Name of Spouse		Spouse's Soc. Sec. No.
Is Spouse Employed? ❑ YES ❑ NO	If yes, Employer Name, Address & Phone Number	Spouse's Date of Birth
Does Spouse have Group Insurance? ❑ YES ❑ NO	If yes, Name & Address of Insurance Company	Policy Number
Is Spouse covered by Medicare? ❑ YES ❑ NO	If yes, Please submit a copy of Medicare ID card	

DEPENDENT INFORMATION (COMPLETE FOR ALL COVERED CHILDREN)

Dependent Child's Name		Relationship to Employee	D.O.B.
If Dependent is 19 Yrs. Or Older Indicate if Student ❑ YES ❑ NO	If yes, Name of School	Full Time? ❑ YES ❑ NO	Is Dependent 19 Yrs of Age or Older and Handicapped ❑ YES ❑ NO
Is Dependent Employed? ❑ YES ❑ NO	If yes, Employer Name, Address & Phone Number		
Is Dependent Covered Under Another Group Policy? ❑ YES ❑ NO	If yes, Name & Address of Insurance		
Is Dependent Covered by Medicare? ❑ YES ❑ NO	If yes, Please Submit Explanation of Benefits	If Divorced Who has Custody of Dependent ❑ MOTHER ❑FATHER	
If Step Child, Name of Natural Father	Name of His Employer, Name & Address of Ins. Co. & Policy Number		
If Step Child, Name of Natural Mother	Name of Her Employer, Name & Address of Ins. Co. & Policy Number		

AUTHORIZATION SECTION

AUTHORIZATION: I hereby authorize any hospital physician or other person who has attended or examined me or my dependents, or furnished medical services or supplies, to disclose when requested to do so any and all information with respect to any illness, injury, medical history, consultation, prescription, or treatment, including copies of all medical records to HERITAGE CONSULTANTS/PROFESSIONAL ADMINISTRATORS. I further authorize HERITAGE CONSULTANTS/PROFESSIONAL ADMINISTRATORS to release all such information and records to an insurance company, insurance agent or broker, and any necessary representative of my employer for purposes of claims administration, investigation, and underwriting. A photostatic copy of this authorization shall be considered as effective and valid as the original.
NOTICE TO FLORIDA CLAIMANTS: Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading nformation is guilty of a third degree felony.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I Authorize the release of any Medical Information Necessary to Process this Claim

SIGNATURE OF INSURED _____ SIGNATURE OF SPOUSE _____