

BENEFIT SUPPORT, INC.
GROUP INSURANCE ADMINISTRATOR
EMPLOYEE INFORMATION UPDATE FORM

P.O. Box 2977
 Gainesville, GA 30503
 (770) 532 - 2690
 (800) 777 - 4782

EMPLOYEE'S STATEMENT

1. Employer's Name		2. Group Number		
3. Employee's Name (Last, First, Middle)		4. Employee's Address (Street, City, State, Zip)		
5. Employee's Date of Birth		6. Employee's Social Security Number		
7. Spouse's Name		8. Is spouse employed? ___ yes ___ no If yes, give name and address of Employer	9. Employer's Phone Number	
10. Spouse's Date of Birth	11. Is spouse covered under any other health insurance? ___ yes ___ no If yes, list the name, address and phone number of spouse's health insurance carrier and policy number.			
12. Dependent Information -- Below list each child, with the oldest first. If age 19 or older, list only if full-time student.	Sex	Birthdate	Relationship	Is there other health insurance coverage?
13. If dependent children have other health insurance coverage please list name, address and phone number of other health insurance carrier. If there is a divorce situation, we will need a copy of the portion of the divorce decree to verify the stipulations for custody and health insurance coverage. If child is over 19 and a full-time student, please list name, address and phone number of school for verification purposes.				

A new Employee Information Update Form must be completed each time there is a change in information (i.e. other insurance information or addition of dependents) or 12-months past the date of signature of this form.

I hereby authorize any Insurance Company, Plan Supervisor, Pre-payment Organization, Employer or provider of medical services to release all information with respect to myself or my dependents listed above, which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information given by me in support of claims is true and correct. A photostatic copy of this authorization shall be considered as effective and valid as the original.

14. Date _____

15. Employee's Signature _____