ELIGIBILITY GUARANTEE FORM

_____
Date

I, _____ hereby certify that I am eligible
Member Name

for Health Plan coverage with _____ as of
Health Plan Name

_____through _____. I
Month/Day/Year Employer Group (if applicable)

have chosen _____ to be my Primary Care Physician.
Physicians Name

I understand that if the above is not true or if I am not eligible under the terms of my Medical and Hospital Subscriber Health Insurance Agreement, I am liable for all charges for the services rendered. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from the above noted medical provider.

_____ _____
Signature of Member (or Guardian) Office Personal

_____
Printed Name of Member (or Guardian)