INSURANCE INFORMATION

Primary Insurance:_____ Member ID #:_____

Phone (of insurance company): _____

Name of Insured:_____ Birthdate:_____ Phone:_____

Name of Employer:_____

Secondary Insurance:_____Member ID #:_____

Phone (of insurance company): _____

Name of Insured:_____ Birthdate:_____ Phone:_____

Name of Employer:_____

Do you have a Health Spending Account? Yes No

I, (print name) _____ authorize Bluegrass Nutrition Counseling to charge my HSA for qualified insurance expenses (i.e. copays, deductibles).

Health Savings Account Info:

Card #_____Exp. Date_____CVV:_____

Name (as printed on card): _____

Relationship to Client: _____

Billing Zip Code:_____

Signature:_____Date: _____

(client or financially responsible party)

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