Georgia Youth CHalleNGe Program

MEDICAL INSURANCE INFORMATION SHEET

This information sheet must be completed in order for the applicant to be enrolled in Georgia Youth ChalleNGe Program.

CANDIDATE'S BIRTH NAME:_____ SSN: _____

HOME ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

PARENT/GUARDIAN NAME:_____ SSN:_____

DO NOT CURRENTLY HAVE ANY TYPE OFMEDICAL INSURANCE?_____YES NO IF YOUR ANSWER IS YES, PLEASE COMPLETE THE FOLLOWING:

ARE YOU CURRENTLY ON MEDICAID? : YES NO MEDICAID ACCT#_____

COUNTY IN WHICH APPLICANT ISCURRENTLY ENROLLED:_____

MILITARY DEPENDENT? : YES NO ____

IF YES, SPONSOR'S NAME:_____ SSN:_____

HOME ADDRESS: _____

(STREET) (CITY) (STATE) (ZIP) TRICARE

ACCOUNT NUMBER: _____

SPONSOR'S MILITARY UNIT:_____ UNIT PHONE: _____

PRIMARY INSURANCE:

NAME:_____ POLICY NUMBER: _____

GROUP NUMBER:_____ POLICY HOLDER: _____

INSURANCE COMPANY ADDRESS:

_____

(STREET) (CITY) (STATE) (ZIP)

INSURANCE COMPANY PHONE NUMBER: (____)_____

SECONDARY INSURANCE:

NAME:_____ POLICY NUMBER: _____

GROUP NUMBER:_____ POLICY HOLDER: _____

INSURANCE COMPANY ADDRESS:

_____

(STREET) (CITY) (STATE) (ZIP) INSURANCE

COMPANY PHONE NUMBER: (_____)_____