# PRIMARY INSURANCE HOLDER INFORMATION

**THIS INFORMATION IS FOR THE WALK IN CLINIC**

TYPE OF INSURANCE___________________ CONTRACT #_________________GROUP #________

POLICY #___________________________________

NAME (FIRST, M.I. LAST)

____________________________________________________________

SEX: __MALE __FEMALE DATE OF BIRTH____/____/____

MAILING ADDRESS_________________________________________________________________

CITY_________________________ STATE_________________ ZIP______________

SOCIAL SECURITY #____- ____- _____ HOME PHONE#_________________________________

EMPLOYER_______________________________________________________________________

IS THIS INSURANCE THROUGH THIS EMPLOYER? __YES __NO COPAY AMOUNT: ___________

PLEASE MAKE SURE THAT WHEN CHECKING IN AT CAMP SANCTA MARIA WE HAVE THE FRONT AND BACK OF POLICY HOLDERS INSURANCE CARD.
ALSO PLEASE HAVE PHOTO ID

ANY QUESTIONS PLEASE CALL CAMP OFFICE AT -248-822-8199

THANK YOU
CAMP SANCTA MARIA