

C . A . , , ! .

1. C .
2. C A D .
3. A , , .
4. A .

STATEMENT OF INSURED

Insured Employee

First Name (Last, First, Middle)	Date of Birth: / /
Home Phone: / /	Alt. Phone:
Emergency Contact (Last, First, Middle)	
Emergency Contact (Home/Work):	Emergency Contact:
Emergency Contact:	

PATIENT INFORMATION

Insured Employee

First Name, Last Name, Middle Initial? ^ Cancer ^ Wellness ^ Critical Illness	
First Name (Last, First, Middle)	Date of Birth: / /
^ Cancer Diagnostic Benefit ^ Accident Only Wellness Benefit ^ Critical Illness Health Screening Benefit	
Please list name of test:	
<p>_____</p> <p>_____</p> <p>_____</p>	
Home Phone:	Date: / /

AUTHORIZATION TO DISCLOSE INFORMATION INCLUDING PROTECTED HEALTH INFORMATION

THIS AUTHORIZATION IS A FIDELITY ADVISORY CARE (AFAC) AUTHORIZATION TO DISCLOSE INFORMATION
