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 OF MEDICAL 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 IS CURRENTLY 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: (_____)_____