

code: GF001



Eligibility Waiver

Subscriber's Full Name

Subscriber's Social Security Number

Subscriber's Date of Birth

I (The Above Named Person) hereby certify that I am eligible for benefits effective:

Effective Date:

For Patient:

First Name

Middle Initial

Last Name

I have chosen **{Physician Name}** to be my medical provider.

I understand if the above is not true, I am responsible for all charges related to services provided to me. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from **{Provider's Office}**.

Signature of Patient or Responsible Party:

Date