ASSOCIATE IN-HOUSE PHARMACY INFORMATION PROFILE

"This form is to be completed by only those Associates and Dependants who are insured by Hamilton as their Primary Medical Insurance Carrier."

ASSOCIATE INFORMATION

LAST NAME_____ FIRST_____ M.I._____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE: HOME: (__) ___-_____ HOSPITAL EXTENSION _____

MALE ____ FEMALE ____ DATE OF BIRTH ____/____/_____

EMPLOYEE #_____

____ NO KNOWN ALLERGIES

____ LIST ALL KNOWN ALLERGIES _____

_____

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DEFINITION OF DEPENDANT:

1- A SPOUSE (IF NOT LEGALLY SEPARATED)
2- A CHILD UNTIL SUCH CHILD'S 19TH BIRTHDAY
3- A CHILD AGE 19 BUT LESS THAN AGE 25 PROVIDED THEY ARE ENROLLED AS A FULL-TIME STUDENT IN A COLLEGE OR UNIVERSITY.

DEPENDANT INFORMATION

1) LAST NAME_____ FIRST_____ M.I._____

MALE ____ FEMALE ____ DATE OF BIRTH ____/____/_____

RELATIONSHIP TO ASSOCIATE_____

____ NO KNOWN ALLERGIES

____ LIST ALL KNOWN ALLERGIES _____

_____

Does this dependant have primary medical insurance coverage through another employer? ____ YES ____NO

EMPLOYEE SIGNATURE _____ DATE _____

USE THE REVERSE SIDE FOR ADDITIONAL DEPENDANTS

DEPENDANT INFORMATION

2) LAST NAME_____ FIRST_____ M.I._____

MALE ____ FEMALE ____ DATE OF BIRTH ____/____/_____

RELATIONSHIP TO ASSOCIATE_____

____ NO KNOWN ALLERGIES

____ LIST ALL KNOWN ALLERGIES _____

_____

Does this dependant have primary medical insurance coverage through another employer? ____ YES ____NO

3) LAST NAME_____ FIRST_____ M.I._____

MALE ____ FEMALE ____ DATE OF BIRTH ____/____/_____

RELATIONSHIP TO ASSOCIATE_____

____ NO KNOWN ALLERGIES

____ LIST ALL KNOWN ALLERGIES _____

_____

Does this dependant have primary medical insurance coverage through another employer? ____ YES ____NO

4) LAST NAME_____ FIRST_____ M.I._____

MALE ____ FEMALE ____ DATE OF BIRTH ____/____/_____

RELATIONSHIP TO ASSOCIATE_____

____ NO KNOWN ALLERGIES

____ LIST ALL KNOWN ALLERGIES _____

_____

Does this dependant have other primary medical insurance coverage through another employer? ____ YES ____NO

(If you need to list more dependants, please make copies of this form and submit)