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## ELIGIBILITY GUARANTEE FORM

I, \_\_\_\_\_

Hereby certify that I am eligible for: \_\_\_\_\_

Health plan coverage as of: \_\_\_\_\_ through: **EMPIRE PHYSICIANS  
MEDICAL GROUP**

I have chosen Dr. \_\_\_\_\_ to be my Primary Care Physician. I understand that if the above is not true or if I am not eligible under the terms of my Medical and Hospital Subscriber Health Insurance Agreement, I am liable for all charges for services rendered. 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 the above noted medical provider.

\_\_\_\_\_  
(Member Signature/Guardian Signature) Date: \_\_\_\_\_

Provider Office Representative Initials: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
(Signature) \_\_\_\_\_  
(Date) 2010

\_\_\_\_\_  
(Signature) \_\_\_\_\_  
(Date) 2011

\_\_\_\_\_  
(Signature) \_\_\_\_\_  
(Date) 2012