Employee Assistance

Behavioral Health Programs

gup & ASSOCIATES, INC.

# INSURANCE INFORMATION FORM

**PLEASE FORWARD THE FOLLOWING INFORMATION:**

Your full name _____

Home Phone _____ Can we leave a message? ____ Yes ____ No

Cell Phone _____ Can we leave a message? ____ Yes ____ No

Work Phone _____ Can we leave a message? ____ Yes ____ No

Email address _____

Home Address _____

Work Address _____

Name of county you live, work, and in close driving proximity for you _____

Date of birth _____

Name of insurance provider with (PPO, HMO, POS?) _____

Group insurance number _____

Individual insurance number _____

Phone number for mental health on the back of your insurance card _____

**Fill out this form electronically or by hand and EMAIL to drgup@gupinc.com**