

Form 3

Proof of Medical Health Insurance Form

\*Please provide photocopy of insurance card for our records with this form

Health Care Provider: \_\_\_\_\_

Policy or Group Number: \_\_\_\_\_

Primary Insurance Holder: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

Coverage Dates: \_\_\_\_\_

Health Care Provider Information Below:

Address:

\_\_\_\_\_  
\_\_\_\_\_

Phone number: \_\_\_\_\_

Fax Number: \_\_\_\_\_