

ID CARD REQUEST FORM

Date: _____

To: IDA Enrollment Department

Fax #: 1-201-337-7454

From: Employer's Name: _____

Employee's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Unique Identification
Number: _____

Social Security Number: _____

Effective Date: _____

Coverage Type: (Please Circle one) S H/W F P/C

Plan Enrolled In: _____

Network being Utilized: _____

Reason for request: _____

Number of Cards Requested: _____ Medical _____ Dental _____ Vision
_____ Rx _____ Other _____

Please note that all Requested ID Cards will be sent to the Employer upon completion.