Child Name:_____
ID#:_____
DOB:_____

ASSIGNMENT OF BENEFITS

I, _____ hereby assign to _____ all benefits provided under the health care plan or medical expense policy as specified below:

_____
_____
_____
_____
_____
_____

The amount of such benefits shall not exceed the medical charges set forth by the provider. All payments under the above are to be made to _____.

_____ _____
Insured's Name Relationship to Child

_____
Date

_____ _____
Insured's Signature Expires