

# 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.*