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.