TakeCare℠
A TanHoldings Company

Off-Island Primary Care Verification Form

Part A: Identification of Off-Island Primary Care Provider

Important Note to Eligible Off-Island Dependent[1]

For the continuation of benefits and coverage under TakeCare Insurance Company, Inc. ("TakeCare"), this verification form needs to be completed and submitted to TakeCare every benefit year withing thirty (30) days after Open Enrollment or qualifying events.

Part B: Information and Authorization

Group Effective Date.:

Group ID No.:

Member ID No.:

Last Name:

First Name:

Social Security Number:

DOB:

Complete OFF-ISLAND Physical Address:

City:

State:

Zip Code:

Primary Care Provider Name:

Primary Care Provider Contact Number:

Primary Care Provider Address:

City:

State:

Zip Code:

I authorize the information above to disclose to TakeCare, all information relative to my status as an Off-Island Member[1] *residing outside the service area as it pertains to past, current, or future TakeCare coverage and benefits.*

Signature of Dependent:

Date:

Signature of Parent **if dependent is a minor:*

Date:

Please return completed form to TakeCare Customer Service Department | Fax: 647-3542 | Email: customerservice@takecareasia.com

[1]*Subscriber and/or spouse residing off-island are not eligible.*