GUARANTEE OF INSURANCE ELIGIBILITY

I hereby certify that I am eligible for Health Plan coverage.

Coverage start date: _____/_____/_____
Month Day Year

Health Plan: _____

Employer Group: _____

Primary Care Physician: _____

I understand that if the above is not true and/or I am not eligible under the terms of my Medical and Hospital Subscriber Health Insurance Agreement, that I am liable for all charges for services rendered. Additionally, if the information listed above is not true, I agree to pay in full for all services rendered within 30 days of receiving a bill from the San Diego Hearing Center, Inc.

Signature: _____ **Date:** _____