Office of
Victim Services

ANDREW M. CUOMO
Governor

ELIZABETH CRONIN ESQ.
Director

HEALTH INSURANCE UPDATE FORM
(TO BE COMPLETED BY CLAIMANT)

CLAIMANT NAME: _____ CLAIM NUMBER: _____

Are you now receiving or currently applying for any medical insurance coverage? Yes____ No____
Complete the following table for each person receiving benefits under this claim. Please include current and pending insurances.

Insurance	Company Name	Policy No.	Effective Date	Persons Covered
Blue Cross				
Blue Shield				
Medicare				
Medicaid				
Major Medical				
Union				
HMO				
Veteran's Admin.				
Workers Comp.				
Dental Insurance				
Vision Benefits				
Prescription Drug Program				
No Fault/MVAIC				
Other Insurance				

If your insurance coverage has terminated or changed since you were awarded benefits, **you must submit a termination of benefit statement from your former insurance carrier, and if applicable, a statement, or copy of your benefit card from your new insurance carrier listing the effective date of coverage**.

I hereby certify that the above information is true and correct to the best of my knowledge. I also understand that knowingly submitting falsified information to the Office of Victim Services is a crime.
Payments may be delayed if this form is not received within thirty (30) days.

_____ _____
Claimant's Signature Date

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