Student Health Insurance

Last Name: _____

First Name: _____

Insurance ID: _____
(Located on your Insurance ID card)

Pre-existing Condition Questionnaire

Thank you for selecting the ISO Health Insurance Plan. SISCO Benefits is the claim administrator of your plan. Please answer the following questions to have your claim processed:

1. Do you have any other insurance or medical plan? ☐ Yes ☐ No

   If yes, please provide the insurance ID card of your other insurance plan.

2. Please provide the condition/symptoms for which treatment was received: _____

   _____

3. Please provide the date when symptoms related to this claim first began: _____/_____/_____
   MM / DD / YYYY

4. During your US residency, have you consulted any physician? ☐ Yes ☐ No

   If yes, provide the name(s), address(es) and telephone number(s) of all doctor(s) consulted along with the date(s) of and reason(s) for the visit(s).

   _____

   _____

I authorize any physician, hospital, company, employer or organization to release the medical history, treatments or benefits payable for this claim to SISCO Benefits. A photocopy of this form shall be just as valid as the original. I certify that I have read all answers to this form, and to the best of my knowledge the information I have given is complete and true.

_____ _____
Signature Date

If you have any questions, please contact a member of our customer service team.

Please send response to:
SISCO Benefits | PO Box 3190 | Dubuque IA 52004-3190
Email: ISOservice@siscobenefits.com
Phone: (833) 577-2586 or Fax: (563) 557-3398