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INSURANCE INFORMATION FORM

Policy #1

Insured's name: _____

Relation to client: _____

Date of birth: _____

Social security #: _____

Insurance company: _____

Policy #: _____

Address for claims: _____

Group #: _____

Employer: _____

Employer: _____

Effective date: _____

Telephone #: _____

Policy #2

Insured's name: _____

Relation to client: _____

Date of birth: _____

Social security #: _____

Insurance company: _____

Policy #: _____

Address for claims: _____

Group #: _____

Employer: _____

Employer: _____

Effective date: _____

Telephone #: _____