FAX COVER SHEET

TO: **Medical Underwriting**
FAX #: **412-544-4009**

FROM:

PHONE:

DATE:

No. of pages (including cover):

Name of Applicant: _____

Applicant's Social Security Number: _____

Policy applied for: _____

Is this information pertaining to an appeal? _____

Is this requested Medical Record information? _____

Is this requested Medical Record information for a dependant? _____

What is the dependants name and Social Security Number? _____

_____