Center for New Beginnings

Sarah Ashe, Director **P.O. Box 1066**
(706 437-0505 **Waynesboro, Ga. 30830**

Insurance Form

Responsible Party: _____ Date of Birth: _____
SSN#_____ Relationship to child:_____
(If different than above)
Address: _____ City/Zip: _____
Preferred Phone Number: _____
Employer: _____ Full-Time/Part Time
Primary Insurance: _____
Subscriber: _____ Date of Birth: _____ SSN: _____
Group Member: _____ Member ID: _____
Address: _____
Phone Number: _____ Effective Date_____
Secondary Insurance: _____
Subscriber: _____ Date of Birth: _____ SSN: _____
Group Member: _____ Member ID: _____
Address: _____
Phone Number: _____ Effective Date_____
****Please remember to submit a copy of your Driver's License & Current Insurance Card****

If you would like to apply for our sliding scale based on income to reduced suggested donation cost please submit the following: copy of Sliding Scale Form ,current Driver's License, Insurance Card and Proof of Income. Please note to take advantage of this service we must have all paper work and forms complete. Thank you!