Last Name: ____________ First Name: _____________

Group #: ____

Insurance ID (located on your Insurance ID card): _______

Eligibility Verification Questionnaire

Thank you for selecting the ISO Health Insurance Plan. Wellfleet is the claim administrator of your plan.

Please advise if you have attended classes during the first thirty (30) days of enrollment.

◯ Yes ◯ No

If yes, please provide a copy of your student transcript and/or a letter from your school showing you have attended classes for the first thirty (30) days of enrollment.

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

Please send response to:
Wellfleet Group, LLC
PO BOX 15369
Springfield, MA 01115-5369
Email: ISOclaims@wellfleet-iso.com
Phone: (855) 664-5837
Fax: (413) 452-5485