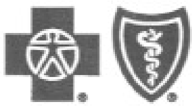

BlueCross BlueShield of Louisiana

An Independent licensee of the Blue Cross and Blue Shield Association.

PRIOR CARRIER HEALTH COVERAGE FORM

Prior carrier information is used to reduce pre-existing condition exclusion periods by giving credit for time served toward any exclusionary time period under another health insurance carrier. This form is designed to capture your prior carrier information so we may apply the proper credit.

INSTRUCTIONS

Section 1: Personal Information- Please complete your name, address, social security number, daytime phone number and group number (if you are enrolled under a group policy).

Section 2a: Prior Carrier Information- Please complete this section if you have had health or dental insurance within the last 12 months. If you have had coverage provided by more than one carrier in the last 12 months, please be sure to give the effective dates and termination dates of the coverage provided by each carrier (attach another sheet if necessary). Since credit for time served under another carrier can only be applied if there has NOT been a lapse in coverage of more than 63 days, we **must** have the termination date of the **prior carrier's coverage. If you have not yet terminated the other coverage, please** give the date the coverage will be terminated (additional information may be requested at the time of termination).

Section 2b: Member Information- Please complete this section if your prior carrier included coverage of dependents. To ensure that proper credit is given for time served, please be sure to include the effective and termination dates of each dependent's coverage.

Section 3: Certification by Subscriber- Please read this section carefully. This section must be signed by the subscriber.

OFFICE USE CONTRACT NO. ______

SECTION 1: PERSONAL INFORMATION

NAME		SOCIAL SECURITY NUMBER
ADDRESS	PHONE NUMBER	GROUP NUMBER

SECTION 2A: PRIOR CARRIER INFORMATION

CARRIER NAME AND ADDRESS	CONTRACT EFFECTIVE DATE
CARRIER PHONE NUMBER	CONTRACT TERMINATION DATE

TYPE OF POLICY: ❑ **LIMITED BENEFITS** (❑ Cancer & Serious Disease ❑ Variable Income Plan ❑ Dental) or ❑ **COMPREHENSIVE**

SECTION 2B: MEMBER INFORMATION

SUBSCRIBER & DEPENDENTS NAME	SEX M/F	RELATIONSHIP	EFFECTIVE DATE **HEALTH** MO/DA/YR	TERMINATION DATE **HEALTH** MO/DA/YR	EFFECTIVE DATE **DENTAL** (If applicable) MO/DA/YR	TERMINATION DATE **DENTAL** (If applicable) MO/DA/YR
SUBSCRIBER						
SPOUSE						
DEPENDENT						
DEPENDENT						
DEPENDENT						

FRAUD STATEMENT– Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE **X** ______ DATE ______

SECTION 3: CERTIFICATION BY SUBSCRIBER

I hereby authorize the release, for three years from the date below, of any/or all documents needed by Blue Cross and Blue Shield of Louisiana or its authorized agent(s) to verify the information represented on this form. A copy of this form may be provided in lieu of the original.

Also, I attest that the information given on this form is accurate and true to my knowledge, and that I will refund immediately any monies paid in error by Blue Cross and Blue Shield of Louisiana as a result of misrepresented information on this form.

______ **X** ______

DATE SUBSCRIBER'S SIGNATURE