Regence BlueCross BlueShield of Utah

An Independent Licensee of the Blue Cross and Blue Shield Association

APPLICATION FOR CREDITING PRIOR COVERAGE

Please complete the following information about any health insurance coverage you and/or your dependents have had at any time during at least the past 24 months. Write **"None"** if there has been no coverage. Obtaining credit for previous coverage is subject to your eligibility under Public Law 104-191 Section 101 and therefore is not guaranteed by the completion of this application. Failure to complete all information and submit a timely "Certificate of Coverage" form or this form with the initial "Application For Membership," may jeopardize or delay your ability to obtain credit for prior coverage for which you and/or your dependents would have otherwise been eligible. Return this form even if you and/or your dependents have had no prior coverage.

Current Employer Group Name _____ Phone Number _____

Employee/Applicant Name _____ Social Security Number _____ Phone Number _____

Prospective Enrollees Applying for prior coverage credit. (List below all enrollees to be considered for prior coverage credit and all corresponding insurance policies.)

Name (First, Last)	**Birth Date**	**Prior Insurer Name**	**Prior Insurer Policy #**	**Prior Insurer Phone #**	**Effective Dates of Coverage** Mo/Day/Yr From - Mo/Day/Yr Thru	**Was this proposed enrollee covered under this policy?** Yes	No
1.	/ /				/ / - / /	☐	☐
2.	/ /				/ / - / /	☐	☐
3.	/ /				/ / - / /	☐	☐
4.	/ /				/ / - / /	☐	☐
5.	/ /				/ / - / /	☐	☐
6.	/ /				/ / - / /	☐	☐
7.	/ /				/ / - / /	☐	☐
8.	/ /				/ / - / /	☐	☐

Comments: _____

I understand that credit for prior coverage will be based upon the information contained in this application. If any information provided is false or incomplete, Regence BlueCross BlueShield of Utah, an Independent Licensee of the Blue Cross and Blue Shield Association, and/or its subsidiaries may without advance notice declare the contract null and void and cancel the coverage retroactive to its original effective date or impose the pre-existing condition waiting period and deny claims that are pre-existing. I further authorize those carriers listed above to release any and all information to Regence BlueCross BlueShield of Utah and/or its subsidiaries in order to comply with the Public Law 104-191 Section 101.

Signature of Employee/Applicant _____ Date Signed _____

THIS SIDE FOR OFFICE USE ONLY

DATE CALLED: _____

PERSON CALLED: _____

PHONE NUMBER: _____

PEC CODE: _____

PEC EFFECTIVE DATE: _____

- Lifetime Maximums Under $1,000,000
- Transplant Coverage Limitations
- Waiver Riders Imposed and Effective Date
- Significant Benefit Exclusions or Limitations
- Mental & Nervous, Physical Therapy, Rehabilitation
- Maternity Excluded or Limited

Name of Proposed Enrollee Listed on Reverse Side	**Benefit Exclusions, Limitations and Waivers**