Louisiana HMO Louisiana

PRIOR CARRIER HEALTH COVERAGE FORM

COMPLETE IN BLACK INK ONLY

Prior carrier coverage is used to reduce pre-existing condition exclusion periods by giving credit for time served under qualified plans. This form may be submitted for creditable coverage determination in place of a Certificate of Creditable Coverage (if permitted by the group employer plan). In order to correctly calculate creditable coverage, it is critical the information you provide is accurate, otherwise claim benefit determinations may be incorrect. You can call your prior carriers or prior employers to obtain the needed information. Please complete this form for each prior carrier enrollment occurring within the last 24 months for both you and your dependents. This form may also be used to report prior carrier dental coverage information if you are enrolling into a group dental plan. NOTE: Do not complete this form for limited scope policies such as vision, long-term care, specified disease (e.g. cancer), fixed indemnity (e.g. $100 per day) since they are not qualified plans.

INSTRUCTIONS

Section 1: Personal Information: Please provide your name, social security number, daytime phone number, your current Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. group policy number, if known.

Section 2a: Prior Carrier Information: Provide the requested prior carrier information.

Section 2b: Member Information: Do not complete the last two columns of this section (*If Group Policy, If Individual Policy)* if you and your dependents have been covered under your prior plan for 18 months or more. If coverage under the prior plan is less than 18 months, we require an additional date in order to determine whether coverage is creditable. Use the following instructions to determine what date should be provided. If you and your dependents enrolled into your *prior group health plan* when initially offered, generally upon hire, then you must also provide the date your waiting period began or if applicable, your plan affiliation date. If you or your dependents enrolled into the prior group plan as a late or special enrollee, you have no waiting period, therefore indicate "N/A". If your prior coverage is under an *individual policy (*a plan not sponsored by an employer) then you must provide the date you submitted a substantially complete application to the carrier.

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).

Waiting Periods When Coverage Never Becomes Effective: Because waiting periods do not count as lapses in coverage, you possibly could have additional creditable coverage that may be added to qualifying creditable coverage identified through using this form. Please speak to your agent or broker if within the last 24-month period, you terminated employment during your group's waiting period OR if within the last 24-month period, your application for an individual policy did not become effective due to either your or the issuer's rejection. The agent should assist you in determining whether we need to adjust your creditable coverage calculation.

SECTION 1: PERSONAL INFORMATION

NAME	SOCIAL SECURITY NUMBER

DAYTIME PHONE NUMBER	CURRENT GROUP NUMBER, IF APPLICABLE

SECTION 2A: PRIOR CARRIER INFORMATION

PRIOR CARRIER NAME	ADDRESS

POLICY NUMBER	PRIOR CARRIER PHONE NUMBER	PLAN TYPE: ☐ Group Employer Plan ☐ COBRA ☐ Individual Plan ☐ Other (describe) _____

SECTION 2B: PRIOR CARRIER MEMBER INFORMATION

NAME	Date of Birth	Dependent Relationship to Subscriber (son, daughter, step-son, etc)	Coverage For: H-Health D- Dental	Coverage Effective Date M/D/Y	Coverage Termination Date M/D/Y	*If Group Policy*, Date waiting period/affiliation period began M/D/Y (if any) or N/A	*If Individual Policy,* Date a Substantially Complete Application Submitted M/D/Y or N/A
SUBSCRIBER							
SPOUSE							

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NAME	Date of Birth	Dependent Relationship to Subscriber (son, daughter, step-son, etc)	Coverage For: H-Health D- Dental	Coverage Effective Date M/D/Y	Coverage Termination Date M/D/Y	*If Group Policy*, Date waiting period/affiliation period began M/D/Y (if any) or N/A	*If Individual Policy*, Date a Substantially Complete Application Submitted M/D/Y or N/A
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							

SECTION 3: AUTHORIZATION & CERTIFICATION BY SUBSCRIBER

I authorize Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. to verify all information provided with my prior carriers or employers. 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 or HMO Louisiana, Inc. as a result of misrepresented information on this form.

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.

Subscriber Signature _____ Date _____