BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Florida Health Options®
Health Options and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

PRIOR / CONCURRENT COVERAGE AFFIDAVIT

Current Group Employer_____. Group # _____.

Applicant's Name _____.

Individuals who currently have coverage or had any healthcare coverage within the past 30 days may be entitled to a credit towards their pre-existing limitation period. Please provide the following information:

NAME OF PLAN /COMPANY	*TYPE COVERAGE A-F (SEE BELOW)	POLICY NUMBER	EFFECTIVE DATE	CANCEL DATE & REASON	LIST ALL FAMILY MEMBERS THAT ARE / WERE COVERED
Most recent:					

*TYPE COVERAGE: A) PPO B) HMO C) Major Medical D) Individual E) Medicare A & B F) Other {specify}

I acknowledge that credit toward my Pre-existing limitation period is contingent upon the complete and accurate disclosure of the information requested above. I represent that information on this form is true and complete and understand that any misstatements may result in denial of benefits and / or termination of coverage.

Applicant / Employee Signature:_____ Date:_____.

Employee Social Security #:_____.