



## Health History Coverage Form

Subscriber: To complete the enrollment process, information on any prior health insurance coverage you and/or your dependents have had in the last 12 months is required. Please attach the "Certificate of Coverage" from your prior health plan(s) or complete the following. Within the past 12 months I have had (check one)

No Prior Coverage
  One Insurance
  Multiple Insurance Carriers

<b>1. INSURANCE CARRIER NAME</b> _____  DATE COVERAGE BEGAN _____	<b>POLICY/SUBSCRIBER NUMBER</b> _____  DATE COVERAGE ENDED _____	<b>TYPE OF POLICY</b> <input type="checkbox"/> GROUP <input type="checkbox"/> DIRECT PAYMENT  <b>COVERAGE TYPE</b> <input type="checkbox"/> FAMILY <input type="checkbox"/> INDIVIDUAL
<b>2. INSURANCE CARRIER NAME</b> _____  DATE COVERAGE BEGAN _____	<b>POLICY/SUBSCRIBER NUMBER</b> _____  DATE COVERAGE ENDED _____	<b>TYPE OF POLICY</b> <input type="checkbox"/> GROUP <input type="checkbox"/> DIRECT PAYMENT  <b>COVERAGE TYPE</b> <input type="checkbox"/> FAMILY <input type="checkbox"/> INDIVIDUAL
DEPENDENT NAME _____		
<b>3. INSURANCE CARRIER NAME</b> _____  DATE COVERAGE BEGAN _____	<b>POLICY/SUBSCRIBER NUMBER</b> _____  DATE COVERAGE ENDED _____	<b>TYPE OF POLICY</b> <input type="checkbox"/> GROUP <input type="checkbox"/> DIRECT PAYMENT  <b>COVERAGE TYPE</b> <input type="checkbox"/> FAMILY <input type="checkbox"/> INDIVIDUAL
<b>4. INSURANCE CARRIER NAME</b> _____  DATE COVERAGE BEGAN _____	<b>POLICY/SUBSCRIBER NUMBER</b> _____  DATE COVERAGE ENDED _____	<b>TYPE OF POLICY</b> <input type="checkbox"/> GROUP <input type="checkbox"/> DIRECT PAYMENT  <b>COVERAGE TYPE</b> <input type="checkbox"/> FAMILY <input type="checkbox"/> INDIVIDUAL
DEPENDENT NAME _____		

IF ADDITIONAL SPACE IS NEEDED FOR DEPENDENTS, PLEASE COMPLETE A SEPARATE SHEET OF PAPER.  
 TO THE BEST OF MY KNOWLEDGE, THE INFORMATION PROVIDED ABOVE IS TRUE AND COMPLETE. I UNDERSTAND THAT FAILURE TO COMPLETE THIS FORM MAY RESULT IN DENIED CLAIM PAYMENT FOR SERVICES.

\_\_\_\_\_  
 PRINT NAME OF SUBSCRIBER

\_\_\_\_\_  
 SIGNATURE OF SUBSCRIBER

\_\_\_\_\_  
 DATE