



**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 health care coverage with no more than a 63-day break in that coverage, may be entitled to a credit toward 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, please specify

I acknowledge that credit toward my Pre-existing Condition Exclusion 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. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Applicant/Employee Signature _____ Date _____

Employee Social Security # _____