BLUE CROSS AND BLUE SHIELD OF ARIZONA (BCBSAZ)
CREDITABLE COVERAGE DISCLOSURE/COB INFORMATION
NORTHERN ARIZONA UNIVERSITY

THIS PAGE MUST BE COMPLETED AND SIGNED IN ORDER FOR YOUR APPLICATION TO BE PROCESSED.

CREDITABLE COVERAGE DISCLOSURE

A pre-existing condition waiting period may apply, subject to your employer's Group Master Contract. A pre-existing condition is defined as a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during no more than a 90 day (three (3) month) period immediately preceding your enrollment date. For purposes of determining a pre-existing condition and pre-existing condition waiting periods, enrollment date means your effective date of coverage under this benefit plan or the first day of the group's eligibility waiting period, whichever is earliest.

IMPORTANT: Pregnancy is not considered a pre-existing condition. The pre-existing waiting period is waived for members transferring from another State of Arizona benefit plan.

Credit will be given for periods of prior creditable coverage as long as there was no period of sixty-three (63) days or more (excluding group eligibility waiting periods) during which you were not covered under any creditable coverage. Creditable coverage is coverage provided under a group health plan (insured or self-insured), an individual insurance policy, Medicare, Medicaid, a public health plan (i.e. AHCCCS), CHAMPUS, Peace Corps, Bonafide Association, Indian Health Service, or the Federal Employee Health Benefits Plan. You have the right to demonstrate to BCBSAZ that you have had prior creditable coverage by providing a Certificate of Creditable Health Coverage or other documentation of such coverage.

CREDITABLE COVERAGE/COB INFORMATION

Do you or any of your dependents currently have health care insurance? ☐ Yes ☐ No

If yes, please list name of insurance company and those individuals covered.

CONTRACTHOLDER _____ I.D. NO./ _____
CONTRACTHOLDER DATE OF BIRTH _____ SOCIAL SECURITY# _____
INSURANCE COMPANY _____ GROUP/POLICY # _____
MAILING ADDRESS _____ PHONE # _____
CITY/STATE/ZIP _____ EFFECTIVE DATE _____
EMPLOYER'S NAME _____ CANCEL DATE _____
MAILING ADDRESS _____ PHONE # _____
CITY/STATE/ZIP _____
TYPE OF COVERAGE ☐ SINGLE ☐ FAMILY TYPE OF PLAN ☐ MEDICAL ☐ DENTAL ☐ OTHER _____
LIST EACH DEPENDENT & THEIR EFFECTIVE DATE (PLEASE SPECIFY) _____

Have you or any of your dependents had health care insurance within the last 18 months? ☐ Yes ☐ No

If yes, please list name of insurance company and those individuals covered.

CONTRACTHOLDER _____ I.D. NO./ _____
CONTRACTHOLDER DATE OF BIRTH _____ SOCIAL SECURITY# _____
INSURANCE COMPANY _____ GROUP/POLICY # _____
MAILING ADDRESS _____ PHONE # _____
CITY/STATE/ZIP _____ EFFECTIVE DATE _____
EMPLOYER'S NAME _____ CANCEL DATE _____
MAILING ADDRESS _____ PHONE # _____
CITY/STATE/ZIP _____
TYPE OF COVERAGE ☐ SINGLE ☐ FAMILY TYPE OF PLAN ☐ MEDICAL ☐ DENTAL ☐ OTHER _____
LIST EACH DEPENDENT & THEIR EFFECTIVE DATE (PLEASE SPECIFY) _____

MEDICAL RELEASE
I agree:

(a) that any physician or institution now or hereafter having information or records relating to care or treatment of me or of any covered family member is authorized and directed, at any time on request by BCBSAZ to furnish such information or records to it
(b) when referred by the personal physician to Arizona Biodyne Centers, the contracting Psychiatrist or Psychologist is authorized to furnish information or records relating to care or treatment to the personal physician
(c) that coverage shall become effective only after this application is accepted by BCBSAZ and the life insurance company and shall be only as provided by the contracts/certificates issued
(d) that if part of the premium is to be met through payroll deduction, I authorize my employer to deduct periodically from my wages or salary, and to remit to BCBSAZ, the amounts necessary to continue coverages in effect
(e) that the foregoing statements shall be used for acceptance of me and eligible dependents and that, if I have misstated or omitted any information, any resulting coverage shall be null and void
(f) that I have requested the insurance provided by my employer's group insurance plan and have designated the beneficiaries, as stated in this form
(g) that I may be required to provide to BCBSAZ additional medical/health information or records, which will be used to evaluate group rates

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Applicant Name (Please print)	Signature X	Date

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