

Creditable Coverage



This form must be completed and signed by the Subscriber (employee) attesting to prior creditable coverage for all family member applying for coverage with AvMed Health Plans.

Please provide names and information for all family members that had coverage under a prior carrier's health plan during the previous 12 months (24 months for groups with fewer than 2 employees):

Name of Employee and Dependents	SS Number	Previous Carrier Name	Group or Member Number	Effective Date	Termination Date	Coverage Type <i>(e.g. individual, employee only, family)</i>

Please forward Certificates of Creditable Coverage from prior carrier(s) to avoid audit.

I hereby affirm that any applicable dependents and I have maintained creditable coverage under the plan(s) as indicated above. I understand and agree that AvMed may audit such information and may request additional evidence of creditable coverage. I understand that if the information provided herein varies from information subsequently submitted, AvMed reserves the right to adjust the pre-existing condition exclusion (PCE) determination of any member accordingly.

I certify that all the information provided is accurate and complete. I further understand that any person who knowingly and with the 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.

Employee Signature: _____ Date: _____