

**PRIOR COVERAGE  
INFORMATION REQUEST**



**Asuris  
Northwest Health**

A Regence Affiliate

P.O. Box 91130  
Seattle, Washington 98111-9230  
1 888 344-5587

Complete this form if you or your dependents are applying for coverage or have recently (within the last 12 months) come onto coverage through Asuris Northwest Health and you had other medical coverage within six months before you started Asuris Northwest Health coverage. Your completed form will be forwarded to the prior insurer(s) to obtain details of your prior coverage. Your signature is necessary as an authorization for this request, so be sure to sign in the space indicated below or processing of your application may be delayed. This information will be used to establish your eligibility for credits on waiting periods. When you have completed this form, submit it along with your application, or if you are already covered, follow the instructions on the cover letter. Please mail your completed form to Asuris Northwest Health, P.O. Box 91130, Seattle, WA 98111-9230, or you may fax to 1-866-297-8001.

Name (Last, First, Middle Initial)	Member ID Number
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Have you or your dependents had other medical coverage within the six months before starting your Asuris Northwest Health coverage?  
 Yes     No

If you answered no, you may skip the following section and simply sign and return the form. If you answered yes, please continue below.

Indicate your medical coverage history immediately prior to this Asuris Northwest Health coverage. Use the back of this form if you need more space or if a dependent had different coverage than that listed here.

Policyholder's Name	Policyholder's Birth Date	Date Coverage Began	Date Coverage Ended	Coverage Still in Effect? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name(s) of Persons Covered				
Employer	Employer Telephone Number		Name of plan under which you were covered	
Insurance Company or Prior Carrier's Name	Company Telephone Number		Policy Number/ID Number	
Type of Coverage	<input type="checkbox"/> Medical	Date this coverage began:    -   -	Date this coverage ended:    -   -	
	<input type="checkbox"/> Dental	Date this coverage began:    -   -	Date this coverage ended:    -   -	
	<input type="checkbox"/> Vision	Date this coverage began:    -   -	Date this coverage ended:    -   -	
	<input type="checkbox"/> Pharmacy	Date this coverage began:    -   -	Date this coverage ended:    -   -	
Did your coverage with this carrier include the following benefits?				
<input type="checkbox"/> Chiropractic <input type="checkbox"/> Maternity <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Psychiatric <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Transplants				
Do you, or your dependents, have any medical condition which was excluded from this coverage by rider or by waiver?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please indicate what conditions were excluded and for whom the exclusion was made:	
Are you, or your dependents, currently taking prescription medications?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please use the space below to list the person(s) name(s) and the name(s) of the medications.	

Are you currently employed?     Yes     No    If yes, does your current employer offer group coverage?     Yes     No

Are you or any dependents currently receiving treatment for an injury or condition that was sustained due to the negligence of another person or entity?     Yes     No \_\_\_\_\_

If yes, what is the injury or condition: \_\_\_\_\_

On behalf of myself and any listed dependents, I hereby authorize Asuris Northwest Health to obtain from and release to any current or previous employer, provider, insurers or health plan carriers indicated on the Prior Coverage from, any information necessary to establish eligibility for credits on waiting periods.

I understand any false or misrepresented information or statements, or failure to inform the company of any coverage at the time of application, may result in retroactive termination of coverage, or retroactive exclusion of coverage for certain conditions. In either case, the company will be entitled to repayment after I have been notified thereof.

All statements and answers on this form are complete and true, and all rights to service are void if found false or incomplete.

Applicant/Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_

Use this space if you need to list more than one coverage for yourself or your dependents.

Policyholder's Name		Policyholder's Birth Date		Date Coverage Began		Date Coverage Ended		Coverage Still in Effect? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name(s) of Persons Covered									
Employer				Employer Telephone Number			Name of plan under which you were covered		
Insurance Company or Prior Carrier's Name				Company Telephone Number			Policy Number/ID Number		
Type of Coverage <input type="checkbox"/> Medical    Date this coverage began:    -   -    Date this coverage ended:    -   - <input type="checkbox"/> Dental    Date this coverage began:    -   -    Date this coverage ended:    -   - <input type="checkbox"/> Vision    Date this coverage began:    -   -    Date this coverage ended:    -   - <input type="checkbox"/> Pharmacy    Date this coverage began:    -   -    Date this coverage ended:    -   -									
Did your coverage with this carrier include the following benefits? <input type="checkbox"/> Chiropractic <input type="checkbox"/> Maternity <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Psychiatric <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Transplants									
Do you, or your dependents, have any medical condition which was excluded from this coverage by rider or by waiver?				<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please indicate what conditions were excluded and for whom the exclusion was made:			

Policyholder's Name		Policyholder's Birth Date		Date Coverage Began		Date Coverage Ended		Coverage Still in Effect? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name(s) of Persons Covered									
Employer				Employer Telephone Number			Name of plan under which you were covered		
Insurance Company or Prior Carrier's Name				Company Telephone Number			Policy Number/ID Number		
Type of Coverage <input type="checkbox"/> Medical    Date this coverage began:    -   -    Date this coverage ended:    -   - <input type="checkbox"/> Dental    Date this coverage began:    -   -    Date this coverage ended:    -   - <input type="checkbox"/> Vision    Date this coverage began:    -   -    Date this coverage ended:    -   - <input type="checkbox"/> Pharmacy    Date this coverage began:    -   -    Date this coverage ended:    -   -									
Did your coverage with this carrier include the following benefits? <input type="checkbox"/> Chiropractic <input type="checkbox"/> Maternity <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Psychiatric <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Transplants									
Do you, or your dependents, have any medical condition which was excluded from this coverage by rider or by waiver?				<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please indicate what conditions were excluded and for whom the exclusion was made:			

### Additional Comments

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