



Pre-Existing Information Form

Reason for this form

This form will need to be completed for claims to be processed. Being a newly enrolled employee, you are subject to pre-existing regulations under this plan. If you were previously insured under another medical plan, you can submit a Certificate of Creditable Coverage, which you should have received from your prior insurer. This will help in either eliminating or reducing the pre-existing period.

Employee's Name: _____ SSN: _____
Last First Middle

RE: Information needed to process your claim(s) for

Dependent Spouse Dependent Child

Name Male Female / / Date of Birth - - SSN

Please complete a separate form for each employee and dependent(s) and then staple together prior to sending to Essential StaffCARE.

Group Name and Number: _____

The Period of Pre-existing review will be the three to six months prior to your effective date.

- 1. Were you previously enrolled in an employer sponsored medical plan for more than a year? Yes No
- 2. Is a Prior Coverage Letter from your prior insurer attached? Yes No

If yes, submit this form along with a copy of a Certificate of Credible Coverage or other form of proof, as referenced above.

If the answer to number 1 above is no, please complete the following:

During the six-month time period prior to being hired or enrolling in this health plan, have you seen any doctor(s)? Yes No

If yes, please list the doctor(s) and the address where you were seen on the following lines:

| | | |
|---------------|---------|--------------|
| Doctor's Name | Address | Phone Number |
| | | |
| Doctor's Name | Address | Phone Number |
| | | |
| Doctor's Name | Address | Phone Number |
| | | |
| Doctor's Name | Address | Phone Number |
| | | |

Thank you for your cooperation.

Please return the completed letter to: Essential StaffCARE, PO Box 6702, Columbia, SC 29260-6702