



Pre-Existing Information Form

Reason for this form

If you were previously insured under another medical plan, you can submit a Certificate of Creditable Coverage, which can be obtained from your previous 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 PAI.

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

Return the completed form to PAI, PO Box 6927, Columbia, SC 29260-6702 or Fax to: (803)-870-8012