



TO BE COMPLETED BY PRIOR INSURANCE COMPANY

- 1) Advantage Health Applicant Name _____ Social Security #. _____
- 2) Participant/Spouse Name _____ Social Security #. _____
- 3) Effective date of coverage: Mo. ____ /Day ____ /Yr. ____
- 4) Date waiting period began (if any) / date of employment: Mo. ____ /Day ____ /Yr. ____
- 5) Date coverage terminated: Mo. ____ /Day ____ /Yr. ____ (Please check here if coverage is still in effect.)
- 6) Please list all **covered** dependents under this plan _____

- 7) If the individual identified in line 1 has at least 12 months of creditable coverage (disregarding periods of coverage before a 63-day break) check here.

PERSON COMPLETING FORM

DATE COMPLETED

INSURANCE COMPANY NAME

BUSINESS PHONE

ADDRESS

CITY

STATE

ZIP

(PRIOR INSURANCE COMPANY)

THE KEMPTON COMPANY
PO BOX 54889
OKLAHOMA CITY, OK 73154-1889
ATTENTION: BILLING

Please send the completed information to The Kempton Company.
If there are any questions, please call our Billing Department at 800-324-9356