



CREDITABLE COVERAGE REQUEST FORM

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