Print Form

PREVIOUS INSURANCE COVERAGE FORM

Subscriber: To complete the enrollment process, information on any prior health insurance coverage you and/or your dependents have had in the last 12 months is required. Please attach the "Certificate of Coverage" from your prior health plan(s) or complete the following.

Within the last 12 months I have had: *(check one)*

☐ No Prior Coverage ☐ One Insurance Carrier ☐ Multiple Insurance Carriers

Subscriber Insurance Carrier Name:	Policy/Subscriber Number:	
Date Coverage Began:	Date Coverage Ended:	
Type of Policy:	☐ Group	☐ Direct Payment
Coverage Type:	☐ Family	☐ Individual
Spouse Insurance Carrier Name:	Policy/Subscriber Number:	
Date Coverage Began:	Date Coverage Ended:	
Type of Policy:	☐ Group	☐ Direct Payment
Coverage Type:	☐ Family	☐ Individual
Dependent Insurance Carrier Name:	Policy/Subscriber Number:	
Date Coverage Began:	Date Coverage Ended:	
Type of Policy:	☐ Group	☐ Direct Payment
Coverage Type:	☐ Family	☐ Individual
Dependent Insurance Carrier Name:	Policy/Subscriber Number:	
Date Coverage Began:	Date Coverage Ended:	
Type of Policy:	☐ Group	☐ Direct Payment
Coverage Type:	☐ Family	☐ Individual

If additional space is needed for dependents, please complete a separate sheet of paper.

To the best of my knowledge, the information provided above is true and complete. I understand that failure to complete this form may result in denied claim payment for services.

Print Name of Subscriber Signature of Subscriber Date

ATLANTIS HEALTH PLAN
By Doctors. For New Yorkers.