Important

BlueCross BlueShield of Oklahoma

DEDUCTIBLE CREDIT FORM

It is the intent of both your employer and Blue Cross and Blue Shield of Oklahoma that all employees and their insured dependents receive credit for deductible expenses with the change of health insurance carriers. Credit is given for health and dental plan deductible expenses only. Credit is not given for copayment expenses or expenses involving other coverages, such as vision plans.

If you or your dependents have satisfied all or part of your deductible required by your employer's health insurance carrier for this calendar year, that amount can be applied to your Blue Cross and Blue Shield of Oklahoma deductible. To receive that deductible credit, you must fill out this form and submit it with your application for health and/or dental coverage. After a review, Blue Cross and Blue Shield of Oklahoma will give you and your dependents credit for the appropriate amount. Please attach a copy of the most recent Explanation of Benefits from your previous health plan for each person claiming deductible credit. This will verify deductible expenses for each member listed.

EMPLOYER							
EMPLOYEE NAME					SOCIAL SECURITY NUMBER		
☐ IF YOU ARE NOT ELIGIBLE TO RECEIVE ANY DEDUCTIBLE CREDIT, PLEASE CHECK THIS BOX; SIGN BELOW; AND RETURN THIS FORM WITH YOUR APPLICATION.							
NAME OF EACH FAMILY MEMBER. LIST LAST NAME IF DIFFERENT.	SEX	BIRTHDATE			AMOUNT APPLIED TO HEALTH DEDUCTIBLE	AMOUNT APPLIED TO DENTAL DEDUCTIBLE	AMOUNT APPLIED TO OTHER DEDUCTIBLE
	M or F	MO.	DAY	YR.			
EMPLOYEE					$	$	$
SPOUSE					$	$	$
DEPENDENT CHILD					$	$	$
DEPENDENT CHILD					$	$	$
DEPENDENT CHILD					$	$	$
DEPENDENT CHILD					$	$	$
DEPENDENT CHILD					$	$	$
DEPENDENT CHILD					$	$	$

I certify that the above information is true and accurate. I authorize physicians, hospitals, and other health care providers or my previous insurance carrier to furnish Blue Cross and Blue Shield of Oklahoma records or copies of records that relate to my medical history or the medical history of my dependents, including diagnosis, care or treatment, dates of service, and related charges. I have attached a copy of the most recent Explanation of Benefits from my previous health plan showing deductible expenses met year-to-date on the plan.

SIGNATURE	DATE	PLEASE RETURN THIS FORM WITH YOUR APPLICATION