cigna healthcare + oscar

PO Box 52146 | Phoenix, AZ 85072

Deductible Credit Form

Please complete this request form to apply your previous group health plan's calendar year deductible to your Cigna + Oscar calendar year deductible for each member of your plan. In order to apply, you must be a member of a new group plan that has transferred its coverage from another insurance carrier with NO lapse in coverage.

Instructions

1. Fill out the fields below, sign and date the form
2. Attach a copy of an Explanation of Benefits (EOB) from your prior insurance carrier for each member (please do not include more than one page per member)
3. Return the form and documentation through one of the following channels:

Cigna + Oscar
P.O. Box 52146
Phoenix, AZ 85072-2146
OR
smallgroupam@hioscar.com

EMPLOYEE INFORMATION		
ID Number (if already enrolled)	Name (First, Middle initial, Last)	Date of Birth _____ - _____ - _____
Group Name	Total Amount	Deductible Amount:
Group ID (if known)	Dates Deductibles Accumulated:	-

DEPENDENT INFORMATION	
Name	Date of Birth - -
Total Amount:	Deductible Amount:
Dates Deductibles Accumulated:	-

DEPENDENT INFORMATION	
Name	Date of Birth - -
Total Amount:	Deductible Amount:
Dates Deductibles Accumulated:	-

DEPENDENT INFORMATION	
Name	Date of Birth - -
Total Amount:	Deductible Amount: :
Dates Deductibles Accumulated:	-

DEPENDENT INFORMATION	
Name	Date of Birth - -
Total Amount:	Deductible Amount:
Dates Deductibles Accumulated:	-

The information provided here is true to the best of my knowledge.

Signature: _____ **Date**: _____