Deductible Credit Form

Receive credit for any amount applied towards the deductible for you and/or your dependents under your prior health insurance carrier's plan. Credit will be applied for any claims incurred during the calendar year you join Aetna.

Please complete this form in its entirety and send or fax all required documentation to:

Attention: AETNA - DEDUCTIBLE CREDIT UNIT
Fax: 859-455-8650
Mail to: Claim address on the back of your Aetna ID card

Employee Information	
Full Name	
Date of Birth	Social Security Number
Address (Street, City, State, ZIP)	
Group Name	Aetna Member ID Card W Number

Deductible credit is requested for:

Name	Relationship	Date of Birth	Amount Requested

Request must include a copy of the last Explanation of Benefits (EOB) statement from your previous health insurance carrier for you and your dependents that states the amount of deductible credit satisfied.

If you have any questions, please contact the member services number on your ID card.

I certify that the above information is accurate and complete to the best of my knowledge.

Signature	Date