Section 7: HIPPA

IMPORTANT NOTICE OF YOUR RIGHT TO DOCUMENTATION OF HEALTH COVERAGE

Recent changes to Federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for preexisting medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a preexisting condition exclusion generally may not be imposed for more that 12 months (18 months for a late enrollee). The 12-month (or 18 month) exclusion is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than though an employer group health plan, a certificate of prior coverage may help you obtain coverage without a preexisting condition exclusion. Contact your State insurance department for further information.

For employer group health plans, these changes generally take effect at the beginning of the first plan year starting after June 30, 1997. For example, if your employer's plan year begins on January 1, 1998, the plan is not required to give you credit for your prior coverage until January 1, 1998.

You have the right to receive a certificate of prior health coverage since July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Check with your new plan administrator to see if your new plan excludes coverage for preexisting conditions and if you need to provide a certificate or other document of your previous coverage.

To obtain a certificate, complete the attached form and return it to:

Gregory and Gregory, Inc.
P.O. Box 1340
Zachary, LA 70791

(225) 654-3311

The certificate must be provided to you promptly. Keep a copy of this completed form. You may request certificates for any dependents (including your spouse) enrolled under your health coverage.

REQUEST FOR CERTIFICATE OF HEALTH COVERAGE

Name of Participant: ______________________

Date:_______________

Address:

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Telephone Number: _____________________

Name and relationship of dependent(s) for whom certificates are requested (and their address if different from above):

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