

Important Notice of Your Rights to Documentation of Health Coverage

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

The Health Insurance Portability and Accountability Act of 1996 limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12 month (or 18 month) exclusion period 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 through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing 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 30th, 1997. For example, if your employer's plan year begins on January 1st, 1998, the plan is not required to give you credit for your prior coverage until January 1st, 1998.

You have the right to receive a certificate of prior health coverage since July 1st, 1996. You may need to provide other documentation for earlier period of health care coverage. Check with your new plan administrator to see whether your new plan excludes coverage for pre-existing conditions, and whether you need to provide a certificate or other documentation of your previous coverage.

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

[Company Name, address, phone number]

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

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REQUEST FOR CERTIFICATE OF HEALTH COVERAGE

Name of Participant: _____ Date _____

Address: _____

Telephone Number: _____

Name and relationship of any dependents for whom certificates are being requested (and their address, if different from above): _____
