

**COBRA, MARYLAND STATE CONTINUATION**  
**AND HIPAA**  
**INFORMATION PACKET**

As a free service to you, Kelly & Associates Insurance Group, Inc. has put together this packet of important information pertaining to COBRA, Maryland State Continuation Coverage and Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, at your request, we can bill your former employees for insurance premiums when they elect to continue their coverage through COBRA or Maryland State Continuation. ***However, it is your responsibility to notify your employees and their spouses or dependents of their continuation of coverage rights.***

We recommend that you have your attorney review and revise the forms to meet the specific terms of your plan and the applicable laws.

Since Kelly & Associates will not be responsible for providing notices or forms, you should ensure that you are complying with state and federal laws on continuation of coverage. Since state and federal laws are constantly changing, we recommend that you seek advice from your attorney on the requirements of notifying employees of their options.

Other important sources of information are:

U.S. Department of Labor, Pension and Welfare Benefits Administration  
200 Constitution Avenue, N.W., Room N-5658  
Washington, D.C. 20210

Maryland Insurance Administration  
525 St. Paul Place  
Baltimore, MD 21202  
Telephone: (410) 468-2000

If you have questions regarding the process of health benefit termination for your employees, please contact Kelly and Associates' Client Services Team at (410) 527-3432 or (888) 708-7192.

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## STATEMENT TO EMPLOYEE

### SAMPLE

### Initial Notification Group Health Continuation Under COBRA

On April 7, 1986, a Federal law was enacted (Public Law 99-272, Title X) requiring that certain employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. (Both you and your spouse should take the time to read this notice carefully.)

If you are an employee of <Company Name> covered by <Group Health Plan Name> you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by <Group Health Plan Name>, you have the right to choose continuation coverage for yourself if you lose group health coverage under <Group Health Plan Name> for any of the following four reasons:

1. The death of your spouse;
2. Termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment with <Company Name>;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by <Name of Group Health Plan>, he or she has the right to continuation coverage if group health coverage under <Name of Group Health Plan> is lost for any of the following five reasons:

1. The death of the employee;
2. Termination of the employee’s employment (for reasons other than gross misconduct) or reduction in the employee’s hours of employment with <Company Name>;
3. The employee’s divorce or legal separation;
4. The employee becomes entitled to Medicare; or
5. The dependent child ceases to be a “dependent child” under the <Name of Group Health Plan>.

Under the law, the employee or a family member has the responsibility to inform the **<Name of Group Health Plan>** Plan Administrator of a divorce, legal separation, or a child losing dependent status under **<Name of Group Health Plan>** within 60 days of the date of the event. **<Company Name>** has the responsibility to notify the Plan Administrator of the employee's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want continuation coverage.

If you do not choose continuation coverage on a timely basis, your group health insurance coverage will end.

If you choose continuation coverage, **<Company Name>** is required to give you coverage, which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended for affected individuals to 36 months from termination of employment if other events (such as a death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. To benefit from this extension, a qualified beneficiary must notify the Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the **<Group Health Plan Name(s)>** and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the **<Plan Administrator>** of the birth or adoption.

However, the law also provides that continuation coverage may be cut short for any of the following five reasons:

1. **<Company Name>** no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is **not** paid on time;
3. The qualified beneficiary becomes covered – after the date he or she elects COBRA coverage – under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA coverage;
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows.

If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the **<Name of Group Health Plan>** may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the **<Name of Group Health Plan>** Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Under the law, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. *(At the end of the 18 month, 29 month or 36 month continuation coverage period, qualified beneficiaries will be allowed to enroll in an individual conversion health plan provided under <Name of Group Health Plan>.)*

If you have any questions about COBRA, please contact **<Company Name and Address>**. Also, if you have changed marital status, or you or your spouse have changed addresses, please notify **<Company Name>** at the above address.

# LETTER TO EMPLOYEE

## SAMPLE

<Date>

Dear <Qualified Beneficiary>:

This is to advise you that your coverage under the <Company Name> Employee Benefit Plan terminated as of <Termination Date> due to <Qualifying Event>. You have the right to continue the health coverage under the Plan, as of the qualifying event, for yourself and your dependents covered under the Plan beyond this date, if you elect to do so in writing, and send in all monthly premiums. This extended coverage is called "COBRA" continuation coverage. An election form is attached. We are also enclosing another copy of the COBRA Continuation Coverage Notice, which would serve as guidance in your COBRA election.

### DEADLINE FOR ELECTION OF COVERAGE

Even if you choose not to elect COBRA continuation coverage, each of your other family members covered under the Plan has an independent right to elect COBRA continuation coverage. In this case, it is important that each family member read this letter and the enclosed Notice.

If COBRA continuation coverage is desired, the attached Election Form must be completed and mailed or delivered to <Company Address> no later than <Date>. (This is the later of 60 days from the date your coverage terminated or 60 days from the date of this Notice.) If you do not send in the Election Form by that date, you will lose your right to elect COBRA continuation coverage.

### PREMIUM RATES

The monthly premium for this COBRA coverage will be <\$\_\_\_\_\_> per month for single coverage, <\$\_\_\_\_\_> per month for family coverage. THESE AMOUNTS ARE SUBJECT TO CHANGE. You will be notified of any change in rates and the reason for the change.

### DEADLINE FOR PAYMENT

Although you have 60 days to make your election, COBRA continuation coverage begins from the date your coverage would have terminated, the qualifying event, if you had not chosen COBRA continuation coverage. THEREFORE, the FIRST premium must be paid retroactively, and is for the period beginning <Date of Termination>. This payment must be made no later than 45 days after the date you mail or bring your signed Election Form to the Plan Administrator. However, it is advisable to include the premium payment with the Election Form to receive prompt payment of any eligible claims.

Premium payments are generally due within 30 days after the first day of each month of coverage.

After your signed Election Form is received, it is your responsibility to pay premiums on a timely basis. If the premium due for any month is not received by the due date, your coverage will be terminated.

### **TYPE OF BENEFITS**

Your COBRA continuation coverage consists of the health benefits to which you were entitled on **<Last Day of Employee Coverage>**.

### **DURATION OF COVERAGE**

If COBRA continuation coverage is elected, and the premiums are paid on time, coverage will continue until the earliest of:

1. **<Date>** that is **<18/36 months>** following the date when your eligibility terminated; or **<Date>** that is 29 months following the date of initial COBRA eligibility, if you are determined to be disabled (for Social Security Disability purposes) and the Plan Administrator is notified of that determination within 60 days and you pay the applicable premium.
2. The date you become covered under any other group health plan.
3. The date you become entitled to Medicare.
4. The date the Plan is terminated.

### **EARLY TERMINATION OF CONTINUATION COVERAGE**

Coverage may terminate early if:

1. The required premium payment is not paid when due.
2. After the date of your continuation coverage election, you and your spouse or dependent child(ren), if any, become covered under another group health plan that does not contain any exclusion or limitation for any of your pre-existing conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan year beginning after June 30, 1997. HIPAA coordinates continuation coverage cut-off rule with these new limits as follows. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your continuation coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the plan may terminate your continuation coverage.

3. After the date of your continuation coverage election, you, your spouse or dependent child(ren), if any, become entitled to Medicare benefits.
4. All of the company's group health plans are terminated.
5. If coverage is extended to 29 months due to disability, a determination that the individual is no longer disabled. NOTE: Federal law requires that you inform the Plan Administrator of any final determination that you are no longer disabled with 30 days of such a determination.

If you or any member of your family are choosing COBRA continuation coverage, please complete both copies of the attached Election Forms, keep one copy for your records and return one copy to the Plan Administrator in the enclosed envelope.

Should you have any questions, please contact me at <Company Phone Number> as soon as possible.

Sincerely,

<Administrative Committee>

<Company Name>

# COBRA CONTINUATION ELECTION FORM

I wish to continue coverage under the <Name of Company> Employee Benefit Plan. I understand that this election is subject to the Plan. I have read and understand the COBRA Continuation Coverage Notice and the letter that accompanied this election form and both COBRA rights and limitations on those rights.

YES  NO

**IF YES, PLEASE ATTACH A NEW APPLICATION**

**Effective date of continuation coverage:** \_\_\_\_\_

**First payment is enclosed:**  YES  NO

(If first payment is not enclosed, you may not be able to access health care coverage until payment is received.)

**Qualifying Event:**

Termination  Death  
 Reduction in hours  Divorce  Other \_\_\_\_\_

**Type of Insurance Selected:**

Health  Dental  Vision

(May not add lines of Insurance until Open Enrollment.)

**Type of Coverage Selected:**

Individual  Husband/Wife  Parent/Child  Family

(Dependents may not be added until Open Enrollment unless a change in family status occurs.)

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Print Name Social Security Number

\_\_\_\_\_  
Signature of Witness

**For Employer to complete:**

Continuation coverage end date: \_\_\_\_\_

Bill to Company:

Bill to Qualified Beneficiary:

\_\_\_\_\_  
Billing address

\_\_\_\_\_  
City State Zip

*[Notice to Employer Group: Kelly and Associates Insurance Group, Inc. can direct bill your former employees for insurance premiums when they elect to continue coverage through State Continuation without charge.]*

## **STATEMENT FOR EMPLOYEE**

SAMPLE

### **MARYLAND CONTINUATION COVERAGE NOTICE**

Under Maryland law, in certain events, where an employer has **two or more employees**, continuation of coverage for certain health benefits is available in the case of the death of the covered participant, or termination of the participant's employment (other than for cause), or divorce of the participant and the spouse.

**1. Coverage for Surviving Spouse and Dependent Child**

The surviving spouse who has been covered for at least thirty (30) days immediately preceding the death of a participant who was a resident of the State of Maryland, covered under the company's health benefit plan for a period of not less than three (3) months, and dependent children who were also covered, or were born to the surviving spouse after the applicable change in status, may elect to continue coverage under the company's health benefit plan by notifying the employer in writing, of the election within forty-five (45) days of the death of the subscriber.

**2. Coverage for Terminated Employees**

A terminated employee, who is a resident of the State of Maryland, covered under the company's health benefit plan for a period of not less than three (3) months, and the terminated employee's spouse and dependent children who were covered under the company's health benefit plan may elect to continue coverage under the company's health benefit plan by notifying the employer, in writing, of that election within forty-five (45) days of the termination of employment.

**3. Coverage for Divorced Spouse and Dependent Child**

A spouse who was covered under a company's health plan for the thirty (30) day period immediately preceding the applicable change in status, and dependent child(ren) who were also covered, or were born to the divorced spouse after the applicable change in status, may continue coverage under the employee company's health benefit plan by notifying the employer, in writing, of the divorce not later than:

- A. Sixty (60) days after the date of the divorce; and
- B. Thirty (30) days after the participant becomes covered under a new company's health benefit plan.

In the event of the death of the covered participant or the participant who is terminated, the period of continuing coverage is from the date of the applicable change in status and ending on the earlier of the eighteen (18) months after the date of the applicable change in status, or until one of the below listed events of termination occurs:

In the case of a divorced spouse, or a dependent child of a subscriber continuing coverage shall end upon the date the subscriber's coverage terminates, or the earliest to occur of the events listed below:

- A. Failure of the covered person to pay the required subscription charges;
- B. Entitlement of the covered person to benefits under Medicare;
- C. Eligibility of the covered person under another company's health benefit plan or HMO;
- D. Coverage of the covered person under a non-group health plan;
- E. In the case of a covered person who is a qualified secondary beneficiary by reason of having been a dependent child, the date on which the covered person would no longer have been covered under the company's health benefit plan if there has been no applicable change in status;  
Qualified Secondary Beneficiary: a covered person other than the participant who is a:
  - 1) spouse of the participant for at least a thirty (30) day period immediately preceding an applicable change in status; or,
  - 2) a dependent child;
- F. The date of remarriage, in the case of a covered person who is a qualified secondary beneficiary by reason of having been the divorced spouse of the participant;
- G. Election by the covered person not to be covered by notifying the employer;
- H. The employer no longer provides health benefit coverage.  
(Except in the event of the employer no longer providing health benefit plan coverage, any event of termination will operate to terminate continuation of coverage only for that specific covered person.)

Notice of an election to continue coverage and of a terminating event should be given to employer on an **Election Statement or a Termination Statement form**, which is available from the employer.

The employer may include an additional two percent (2%) administrative fee with the cost of the required subscription charges to continue coverage.

### **ADDITIONAL MARYLAND CONTINUATION RIGHTS**

A covered person(s) electing the option of continuing coverage under the plan is required to remit monthly to the employer the entire cost of the coverage. The entire cost is the sum of the amount that would have been contributed for coverage by the employer plus the amount that the former employee would have contributed if coverage had not terminated.

A covered person(s) whose coverage terminates should be notified of their option to continue coverage under the plan, on or before the termination date, but not more than sixty-one (61) days before termination date. If not timely notified, the covered person has the right to apply for continuation for coverage within thirty-one (31) days after the date of the late notice; however, this period of time may not extend beyond ninety (90) days after the termination of coverage.

Written notice should be sent to the covered person at their last known address. At the end of the period of continued coverage, the covered person may convert to a non-group health plan.

# LETTER TO EMPLOYEE

SAMPLE

## MARYLAND STATE CONTINUATION OF COVERAGE

<Date>

Dear <Qualified Beneficiary>:

This is to advise you that your coverage with <Company Name> terminated as of <Date of Termination> due to your terminating employment with us. You have the right to continue the health coverage under the Plan, as of <Date>. Coverage is available for yourself and your dependents covered under the Plan beyond this date. If you elect to do so, you must submit your intentions in writing and send in all monthly premiums. If you choose continuation coverage, <Company Name> is required to give you coverage, which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for <Eligible Time> for <Qualifying Event>.

This extended coverage is called Maryland Continuation of Coverage. An election form is attached. We are also enclosing a copy of the Maryland Continuation Coverage Notice to serve as guidance in your election. If Maryland Continuation Coverage is desired, the attached election form must be completed and mailed to:

<Company Name> • <Address> • <City, State and Zip>

The election form must be returned no later than <Number of Days> from <Date of Event>. If you do not return the election form by that date, you will lose your right to elect Maryland Continuation Coverage. Although you have <Number>days to make your election, Maryland Continuation Coverage begins from the date your coverage would have terminated, <Date of Event>, if you had not chosen Maryland Continuation Coverage. THEREFORE, the FIRST premium must be paid retroactively, and is for the period of time beginning <Date of Event>.

After your signed election form is received, you will be advised regarding the amount of your premium. **Subsequent monthly payments will be due on the first day of the calendar month for which coverage is being provided.** It is your responsibility to pay premiums on a timely basis. If the premium due for any month is not received by the due date, your coverage will be terminated.

Should you have any questions, please call <Phone Number> as soon as possible.

Sincerely,

<Company Name>

# MARYLAND CONTINUATION ELECTION FORM

I wish to continue coverage under the <Name of Company> Employee Benefit Plan. I understand that this election is subject to the Plan. I have read and understand the MD Continuation Coverage Notice and the letter that accompanied this election form and both MD Continuation rights and limitations on those rights.

YES  NO

**IF YES, PLEASE ATTACH A NEW APPLICATION**

**Effective date of continuation coverage:** \_\_\_\_\_

**First payment is enclosed:**  YES  NO

(If first payment is not enclosed, you will not be able to access health care coverage until payment is received.)

**Qualifying Event:**

Termination of Employment  Death  
 Divorce

**Type of Insurance Selected:**

Health  Dental  Vision

(May not add lines of Insurance until Open Enrollment.)

**Type of Coverage Selected:**

Individual  Husband/Wife  Parent/Child  Family

(Dependents may not be added until Open Enrollment unless a change in family status occurs.)

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Print Name Social Security Number

\_\_\_\_\_  
Signature of Witness

**For Employer to complete:**

Continuation coverage end date: \_\_\_\_\_

Bill to Company:

Bill to Qualified Beneficiary:

\_\_\_\_\_  
Billing address

\_\_\_\_\_  
City State Zip

## **SUMMARY EXPLANATION OF HIPAA**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is considered by many to be the most significant piece of legislation affecting employee health plans since the enactment of COBRA. HIPAA affects virtually all employer-sponsored health plans and all group and individual health insurance contracts. Virtually every employer with a health plan, every insurance carrier, and those who provide services to or with respect to either, needs to be intimately familiar with HIPAA's requirements and to create procedures to ensure that the affirmative obligations imposed by HIPAA are met. Below is a summary of some of HIPAA's requirements.

### **1. Limitations on pre-existing condition exclusions:**

Plans may not impose pre-existing condition exclusions for longer than twelve (12) months and may not look back more than six (6) months in determining whether a condition was "pre-existing."

Pre-existing condition exclusions must be reduced by prior periods of "creditable coverage" under other plans.

- A. Creditable coverage periods may be disregarded if there is a sixty-three (63) day gap in coverage.
- B. A plan must certify (1) the period of creditable coverage under the plan, (2) any creditable coverage under COBRA, and (3) any waiting period under the plan.

### **2. Certification Notification:**

- A. At the time an individual ceases to be covered under the plan or otherwise becomes covered under COBRA, a certificate will be issued fourteen (14) days from the date of notification of the qualifying event.
- B. In the case of COBRA coverage, at the time the individual ceases to be covered under COBRA, a certificate will be issued as soon as reasonable.
- C. On the request of an individual made not later than twenty-four (24) months after the date of cessation of coverage under either of the above, whichever is later, a certificate will be issued as soon as reasonable after request.
- D. Certificates may be issued when COBRA election and termination notices are issued.
- E. Dependent beneficiaries:
  - 1) May request a written certificate of creditable coverage.
  - 2) Plan or issuer must make a reasonable effort to collect information for dependents and include it on certificate.

**3. Responsibilities of plan and issuers:**

The obligation to provide a certificate is imposed on both the plan and each health insurance issuer that provides coverage.

**Exceptions:**

- A. Another party provides the certificate.
- B. An agreement between the plan and issuer where issuer agrees to provide certificate.
- C. Issuer is not required to provide certificates for coverage periods for which it was not responsible.
- D. Company switches from one carrier to another.

**4. Certificates procedures**

- A. Mail first class to the participant's last known address.
- B. Use separate certificates for participants and dependents if not identical information.
- C. Use model certificate.
- D. Keep copy of certificate in personnel file.

**5. Notice of period of pre-existing condition exclusion**

Within a "reasonable period of time" determination and notification must be made as to the period of the "pre-existing condition" exclusion.

Basis of determination must include the source and substance of information relied upon if pre-existing condition will still be imposed.

- A. Must explain the plan's appeals procedure, and
- B. The opportunity of the individual to present additional evidence.

**6. Notice of special enrollment periods must be provided to certain individuals and dependent beneficiaries.** The following must be advised of the special enrollment period:

- A. Individuals losing other coverage
  - 1) If covered under another plan at the time coverage was previously offered by the new employer to the employee or individual;
  - 2) If employee stated in writing at the time that coverage under another plan was the reason for declining enrollment;
  - 3) If the coverage of the employee or dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and the coverage was terminated as a result of loss of eligibility for the coverage, or employer contributions were terminated; and
  - 4) If under the terms of the plan, the employee requests enrollment not later than thirty (30) days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions as described above.

B. Dependent beneficiaries

- 1) If the plan makes coverage available to dependents of any individual;
- 2) If the individual is the participant under the plan; and
- 3) If a person becomes a dependent of the individual through marriage, birth or adoption.

Then the plan must provide for a dependent special enrollment period during which the person may be enrolled under the plan as a dependent of the individual.

**7. Penalties**

The failure to comply with certain provisions of HIPAA can result in a **\$100.00 a day penalty per individual.**

**CERTIFICATE OF COVERAGE FORM**

SAMPLE

**CERTIFICATION OF GROUP HEALTH PLAN COVERAGE**

**IMPORTANT** - This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice and or diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: \_\_\_\_\_
2. Name of group health plan: \_\_\_\_\_
3. Name of participant: \_\_\_\_\_
4. Identification number of participant: \_\_\_\_\_
5. Name of any dependents to whom this certificate applies: \_\_\_\_\_  
\_\_\_\_\_
6. Name, address and telephone number of plan administrator or issuer responsible for providing this certificate:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. For further information, call: \_\_\_\_\_
8. If the individual(s) identified in line 3 and line 5 has at least 18 months of creditable coverage disregarding periods of coverage before a 63-day break, check here  and skip lines 9 and 10.
9. Date of waiting period or affiliation period (if any) began: \_\_\_\_\_
10. Date coverage began: \_\_\_\_\_
11. Date coverage ended: \_\_\_\_\_ or check  if coverage is continuing as of the date of this certificate: \_\_\_\_\_

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

# NOTICE TO EMPLOYEE OF EXCLUSION

SAMPLE

## **NOTICE OF PRE-EXISTING CONDITION EXCLUSION**

The <Name of Plan> has a pre-existing condition exclusion. <Define the Pre-existing Condition>.

The maximum period that the exclusion can apply is <Number>. That period is reduced by prior health coverage, so you will need to determine how much prior health coverage you had. Remember that if there has been a break of 63 days or more during which you had no health coverage, then the plan may be able to disregard your old coverage. Time spent in any waiting period for coverage does not count toward the 63-day break.

1. **Proof of previous health coverage.** Your old plan must give you a certificate showing how much coverage you had under that plan. The plan must give you the certificate shortly after you become eligible for COBRA coverage, shortly after your coverage ends, and at any other time you request it while you are covered or up to 24 months after your coverage ends. If you become covered by <Name of Plan> which has a pre-existing condition exclusion, you may use the certificate to show how long you had coverage under your old plan.
2. If you do not have a certificate, you can prove your prior coverage by producing documentation or other evidence.
3. The plan will notify you of any length of time that a pre-existing condition exclusion may apply to you after counting your previous coverage.

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According to the information supplied to the Plan Administrator, your prior health coverage <will or will not> reduce the pre-existing condition exclusion period. The amount of the reduction is <\$. . .>. The basis of the determination, including the source and substance of the information on which the plan (or issuer) relied upon in making this determination is as follows:

A copy of the plan's appeals procedures is attached. Please follow these procedures if you dispute the determination that a pre-existing condition exclusion period will be imposed. You have the opportunity to present additional evidence to the Plan Administrator to dispute the determination of the period of pre-existing condition exclusion.

If you have any questions on the Notice of Pre-existing Condition Exclusion, please contact the Plan Administrator at <Address> or telephone <**Name of Contact Person and Telephone Number**>.

# NOTICE TO EMPLOYEE OF ENROLLMENT RULES

## SAMPLE

### NOTICE OF SPECIAL HIPAA ENROLLMENT RULES

- **Special enrollment rights.** HIPAA gives you and your family a special opportunity to enroll in **<Name of Plan>** under two situations:
  1. If you lose other coverage, including COBRA coverage.
  2. If you have a new spouse or dependent.In these two situations, you (or your spouse or dependent) can be enrolled in **<Name of Plan>** even if the plan normally would not allow enrollment at that time.
- **Special enrollment because of loss of the coverage.** You (and your spouse and dependents) might have been eligible to enroll in **<Name of Plan>** at an earlier time but you decided not to because at that time you (or your family members) had other coverage (for example, under the plan of your spouse's employer). In that case, if you (or your family members) later lose the other coverage, **<Name of Plan>** generally must allow you (and your family members) to enroll. You have 30 days after that other coverage is lost to request enrollment, and enrollment will be the first day of the month after the plan receives your completed request.
- This special enrollment right generally is available only if the coverage is lost because it is no longer available (and not lost because of failure to pay the premium or for cause, such as submitting a fraudulent claim). You are not required to elect COBRA coverage in order to have a special enrollment right; however, if you do elect COBRA coverage, you must continue it for the entire period it is available to you in order to preserve this special enrollment right.
- **Special enrollment because of a new spouse or dependent.** If you marry, then you, your spouse, and any new dependents as a result of the marriage have special rights to enroll. If a child is born, you adopt a child, or a child is placed for adoption with you, then you, your spouse, and the new child also get special rights to enroll.
- To be entitled to special enrollment for a new spouse or dependent, you must either be covered under the plan or be eligible to be covered under the plan. You have 30 days after the marriage, birth, adoption, or placement for adoption to request enrollment.
- If you marry, the plan must cover you, your spouse, and any new dependent by the first day of the month after the plan receives your completed request.
- If you have a new child, the plan must cover you and your spouse and the child from the date of birth, adoption, or placement for adoption.

HIPAA-Enrollment Rules

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If you have any questions on the Notice of Special HIPAA Enrollment Rules, please contact the Plan Administrator at <Address> or telephone <Name of Contact Person and Telephone Number>.