HB-0327-0797

CERTIFICATE OF
GROUP HEALTH PLAN COVERAGE

IMPORTANT:

This certificate is being provided to you in compliance with the requirements of the Federal Health Insurance Portability and Accounting Act (HIPAA) of 1996. It provides evidence of your prior health coverage in the State Health Benefits Program. You may need to furnish this certificate to your new insurer 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, 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. Name of participant: _____
2. Identification number of participant: _____
3. Date of this certificate: _____
4. Name of any dependents to whom this certificate applies: _____

   _____
5. Name of group health plan: _____
6. Name, address, and telephone number of issuer responsible for providing this certificate:

   _____

   _____

   _____

   _____
7. For further information, call: _____
8. If the individual(s) identified in line 1 and line 4 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 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 covered dependent.

INSTRUCTIONS FOR COMPLETING THE HIPAA CERTIFICATE OF COVERAGE

The completion of a Certificate of Coverage is a requirement of the federal Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that group health plans provide a Certificate of Coverage automatically to any covered employee or dependent who loses group coverage after June 1, 1997. HIPAA also requires that individuals covered by a group plan who lost coverage between June 1, 1996 and June 1, 1997 be provided a Certificate of Coverage upon request of that individual or his/her designated agent (e.g., new group insurance provider). In the SHBP, the participating local employer or State payroll office has the responsibility for providing required Certificates of Coverage.

ITEM 1: Insert the full name of the covered participant requesting the Certificate.

ITEM 2: Insert the participant's Social Security number, which is the health coverage identification number used by the SHBP.

ITEM 3: Insert the date you are completing the form.

ITEM 4: Insert the full name(s) of any dependent(s) covered under the participant's health coverage at the time of termination of coverage. Indicate any dependent(s) who did not have coverage for the same time period as the participant. For example, if the participant was covered for over 18 months, but the dependent(s) was only covered for eight months, indicate that on the form.

ITEM 5: Insert the name of the SHBP health plan that covered the participant.

ITEM 6: In most cases, the name, address, and phone number of the employer issuing the certificate will be inserted here. If the Certificate is being issued subsequent to the termination of coverage under COBRA, the SHBP's COBRA Administrator will complete this form and insert its identifying information here.

ITEM 7: Insert the same telephone number indicated in Item 6.

ITEM 8: Show the period of time for which the participant is entitled to credit under his/her new plan's pre-existing condition exclusion provisions (if any). This includes the period of time the participant was covered under the SHBP plan, either as an active employee or on any other basis, including COBRA. If the participant went 63 or more consecutive days without health coverage, any coverage that the participant had before the significant break in coverage is ignored. A waiting period before an employee is eligible for plan coverage does not count either as part of a significant break in coverage or in an individual's total of creditable coverage. You must also show the period of coverage for dependent(s) if different from the participant. Do this in Item 4. The longest pre-existing condition period under HIPAA is 18 months, therefore if the participant was covered by a SHBP plan for at least 18 months, that is all that needs to be reported here. If the coverage period was shorter than 18 months, the following must be reported in Items 9 through 11:

- the first day of the waiting period completed by the participant, if any (this is the period between the date of hire and the start of coverage);
- the first day of the participant's creditable coverage;
- the last day of the participant's creditable coverage.

ITEM 9: Insert the day the waiting period (if any) began. This would be the first day at work for a new employee whose coverage does not start immediately.

ITEM 10: Insert the date coverage began.

ITEM 11: Insert the date coverage ended. If you have confirmation that coverage under COBRA or the SHBP Retired Group is continuing, then check the coverage continuing block. Do not check the coverage continuing block if you are not certain that a COBRA or Retired Group application has been initiated and the enrollment processed.