

# INSURANCE PORTABILITY LAW (IPL) APPLICATION



Please refer to the instructions on reverse side for important information.

Eligibility Department, Post Office Box 66678, Baton Rouge, LA 70896

**1. I have read the portability eligibility criteria and declare:**

- I may be eligible based on the information provided below.
- I am not eligible for a reduction/elimination of the pre-existing condition limitation.  
(If you are not eligible, complete, sign, and date sections 1 and 2 only and return form to OGB)

\_\_\_\_\_ signature \_\_\_\_\_ date

**2. Employee information (Please type or print. If more space is needed, please use an additional application form.)**

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number

\_\_\_\_\_ Last Name, First Name, Middle Initial

_____ Mailing Address (of health plan)	_____ City	_____ State	_____ Zip Code	_____ Home Phone
_____ Agency Name	_____ Agency Number	_____ Date Employed	_____ Work Phone	

**3. Dependent Information (Dependents to be covered by Group Benefits or HMO)**

Name	Date of Birth	Social Security Number	Relationship
_____	_____ / ____ / ____	_____ / ____ / ____	_____
_____	_____ / ____ / ____	_____ / ____ / ____	_____
_____	_____ / ____ / ____	_____ / ____ / ____	_____
_____	_____ / ____ / ____	_____ / ____ / ____	_____

**4. Prior Health Plan Coverage (A separate application is required for each health plan.)**

\_\_\_\_\_ Name of Policy Holder \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number

\_\_\_\_\_ Name of Health Plan \_\_\_\_\_ Policy Number

\_\_\_\_\_ Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone

**• note: Information requested in double lined areas is to be provided by the health plan named above or the employer.**

Policy type: \_\_\_\_\_ group \_\_\_\_\_ individual Date coverage effective \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date coverage terminated \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

**5. Dependents (List dependents covered – include policy number if different from policy holder.)**

Name	Policy number	Date of Birth	Date coverage effective	Date coverage terminated
_____	_____	_____ / ____ / ____	_____ / ____ / ____	_____ / ____ / ____
_____	_____	_____ / ____ / ____	_____ / ____ / ____	_____ / ____ / ____
_____	_____	_____ / ____ / ____	_____ / ____ / ____	_____ / ____ / ____
_____	_____	_____ / ____ / ____	_____ / ____ / ____	_____ / ____ / ____

According to our records, the information provided above is correct.

\_\_\_\_\_ Name of Health Plan/Employer \_\_\_\_\_ date

\_\_\_\_\_ Signature and Title of Representative/Agent Verifying Information \_\_\_\_\_ Telephone Number



# Insurance Portability Law

## About the Insurance Portability Law

Eligible state and school board employees who apply for coverage with Group Benefits or a participating HMO are subject to a Pre-Existing Condition (PEC) limitation. Any illness, injury, disease, or condition for which any treatment was received within the six months prior to the effective date of coverage will have no benefits available for the 12 months following the effective date of coverage. The Insurance Portability Law (IPL) could reduce or even eliminate the one-year PEC limitation if the applicant meets certain criteria.

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### Criteria for IPL Eligibility

To be eligible for consideration under the Insurance Portability Law, applicants (including eligible dependents) must meet the following criteria:

1. Must have been covered under an eligible group or private plan. (Foreign National Health Insurance is not considered an eligible plan.)
2. Coverage under the other plan(s) must have been continuous. (The 12-month PEC limitation may be reduced by the number of months of continuous prior coverage.)
3. No more than 63 days must have elapsed between the date prior coverage terminated and the application/enrollment date of OGB/HMO coverage.
4. Prior coverage must terminate before portability can apply.

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### Instructions for Completing IPL Application

Applicants for coverage must complete an Enrollment/Change document (GB-01) and an IPL Application form. Late applicants must also complete a statement of health form. Only the GB-01 form needs to be returned to the Human Resources/Payroll office for forwarding to OGB. The fully completed IPL Application with proof of prior insurance should be mailed directly to OGB.

1. If eligible under the IPL criteria, the application must be completed in its entirety. A separate IPL application must be completed for each prior health plan.
2. The applicant completes section 1-5, where applicable.
3. The applicant must provide proof of insurance coverage by submission of a Certificate of Prior Coverage.
  - a. Proof of coverage must be provided for the insured period immediately preceding the application/enrollment date of OGB/HMO coverage (up to 12 months).
  - b. Information requested in double-lined boxes must be completed by prior health plan representative. Required data may be supplied on company forms/letterhead of prior health plan, if preferable. An authorized signature or company stamp will verify the document.
  - c. Completed and signed application must be returned to the OGB.
  - d. The OGB will notify the employee of the determination under IPL.

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### Important!

Responsibility for providing proof of prior insurance coverage lies with the employee requesting IPL consideration. Applicants will have a 12-month PEC limitation until the fully completed IPL application is received and approved by the Office of Group Benefits. If the applicant is eligible, the PEC limitation will be adjusted retroactive to the date of coverage.