

HIPAA Eligibility Form for Individual Medical

Application# _____

IMPORTANT HIPAA RIGHTS NOTICE: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing condition exclusion and/or a rider excluding a specific condition. This coverage may significantly differ in plan design, cost-sharing obligations and premium charged from the coverage for which you have applied.

Completion of this form is required in order to determine whether or not you are an “eligible individual” entitled to such a plan, as defined by HIPAA and your state’s statute. Refer to the state specific underwriting guidelines for the definition. Please answer the following questions for all family members applying for coverage under HIPAA. **This form must be returned within 21 days of receipt. Include a copy of your certification of previous coverage. Please allow 7 to 14 days to verify eligibility.**

1) Do any applicants have 18 months previous continuous creditable coverage? . . . Yes If yes, list below No

*Name of Prior Medical Carrier, Policy # & Phone #	Policyholder Name & social security #	Applicants covered under this carrier	Effective Date	Termination Date	Reason for Termination

** Please list all prior medical plans you have been insured under during the past 18 months.*

2) Was your most recent coverage under a group health plan, governmental plan or church plan? Yes No

3) Was your most recent coverage an individual plan? Yes No

4) Have you had a break in coverage of 63 days or more during the past 18 months? Yes No

5) Are you currently eligible for coverage under a health plan provided by your employer or your spouse’s employer?. Yes No

6) Are you eligible for coverage under Medicare or Medicaid? Yes No

7) Was coverage under COBRA or a state continuation plan made available to you? Yes No

8) If yes, did you elect coverage under COBRA or state continuation and completely exhaust any coverage available? Yes No

9) If no, please explain why COBRA or state continuation was not made available to you?

10) Please provide your prior employer’s name and telephone number for verification purposes:

I represent that all of the above answers are correct to the best of my knowledge and belief. I understand that submission of this form does not automatically qualify me under HIPAA.

Signature of applicant _____ Date _____