



## STATEMENT OF PHYSICAL CONDITION

Type of Coverage  employee only  employee and child(ren)  employee and spouse  family

Mental Health/Substance Abuse Rider  yes  no

Include all persons applying for coverage. Attach additional sheets if necessary.

Employee Name	Sex	Date Of Birth	Age	Height	Weight
Name and Address of Physician					Date Last Seen
Name of Dependent	Sex	Date Of Birth	Age	Height	Weight
Name and Address of Physician					Date Last Seen
Name of Dependent	Sex	Date Of Birth	Age	Height	Weight
Name and Address of Physician					Date Last Seen
Name of Dependent	Sex	Date Of Birth	Age	Height	Weight
Name and Address of Physician					Date Last Seen

To the best of your knowledge and belief, have you or any of the persons named above been medically treated or medically advised of any of the following within the last six months:

Yes	No	Condition	First Name and Birthdate of Person Treated or Advised
		A. Alcohol/Substance Abuse	
		B. Epilepsy	
		C. Nervous, Mental, or Emotional Condition	
		D. Abnormal Blood Pressure	
		E. Heart Condition(s)	
		F. Blood or Circulatory Condition(s) including disorders of the immune system such as AIDS	
		G. Lung or Respiratory Condition(s)	
		H. Ulcer of Stomach or Duodenum	
		I. Rectal/Colon Condition(s)	
		J. Gallbladder Condition(s)	
		K. Digestive Condition(s)	
		L. Kidney or Urinary Tract Condition(s)	
		M. Thyroid Condition(s)	
		N. Diabetes	
		O. Gout	
		P. Eye Condition(s)	
		Q. Ear Condition(s)	
		R. Arthritis, Rheumatism	
		S. Disorder(s) of Back, Spine, Bones, Muscles, or Joints	
		T. Cancer, Tumor, Abnormal Growth(s)	
		U. Skin Condition(s)	
		<b>MALE ONLY</b> V. Disorder of Prostate or Reproductive Organs/Genital Organs	
		<b>FEMALE ONLY</b> W. Pregnant Now? If yes, give anticipated delivery date.	
		X. Do you now have or have you ever had any reproductive organ/genital disorder or breast disease?	
		Y. Other (Specify)	

Yes  No To the best of your knowledge and belief, within the last six months have you or any of the persons named above had any physical impairment, deformity, sickness, operation, injury, or check-up not listed above?

Complete the following for each "yes" answer in the questions above. Attach additional sheets if necessary.

Patient's First Name	Medical Condition	Date Last Seen	Result <input type="checkbox"/> Still Being Treated <input type="checkbox"/> Released	Name/Address of Physician or Hospital
Patient's First Name	Medical Condition	Date Last Seen	Result <input type="checkbox"/> Still Being Treated <input type="checkbox"/> Released	Name/Address of Physician or Hospital
Patient's First Name	Medical Condition	Date Last Seen	Result <input type="checkbox"/> Still Being Treated <input type="checkbox"/> Released	Name/Address of Physician or Hospital
Patient's First Name	Medical Condition	Date Last Seen	Result <input type="checkbox"/> Still Being Treated <input type="checkbox"/> Released	Name/Address of Physician or Hospital

# 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.

### 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 will be adjusted retroactively to the number of months of continuous prior coverage.)
3. No more than 63 days must have elapsed between the last date of OGB/HMO coverage and the effective date of the new OGB/HMO coverage.

*Portability Form*

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Applicants for coverage must complete an application form. Applicants must also complete a statement of health for each prior health plan and forward it to the office for forwarding to OGB. The fully completed application must be returned to OGB.

Applicants  
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1. If eligible under the IPL criteria, the applicant must complete a statement of health for each prior health plan.
2. The applicant completes section 1-5, which contains the required information.
3. The applicant must provide proof of insurance coverage under a prior health plan.
  - a. Proof of coverage must be provided for the 12 months prior to the effective 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.

ent date

### 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.

# 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.)

\_\_\_\_\_ Last Name, First Name, Middle Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number

\_\_\_\_\_ Mailing Address \_\_\_\_\_ 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