Program Separation Packet Checklist

For All Outgoing House Officers

Residents, please take action as needed

NPI / Medicaid Numbers

Licensure

Long Term Disability Insurance

Credentialing and Verifications

Malpractice Insurance/Moonlighting

Health Insurance and Retirement

**Check with coordinator if all requirements are being met or have been met in order for you to complete the program.*

Thank you,

GME office
504-568-4006

Please visit websites in this packet, for any updated unformation

Revised 01-2010

This packet should be issued to ALL residents/fellowing who are completing the program in their final year

Program Separation Packet for All Outgoing House Officers

As you leave your program, there are numerous tasks and topics that you need to address and/or complete to ensure that your transition into the "real world" goes more smoothly. There is a list for those who *stay* in Louisiana and a list for those who *do not* stay in Louisiana upon graduation.

If you are planning to continue to work at LSU or in the State of Louisiana, you will need to address the following topics:

NPI and MEDICAID NUMBERS

To modify your NPI registration, you must go to the National Plan & Provider Enumeration System (https://nppes.cms.hhs.gov). Please update your new home and office address and update your registration with a new Taxonomy Code corresponding to the license that you now hold and practice type. If you originally applied for your NPI online and still know your login information, you can update it online. If you no longer have your NPI login information, complete the application available at the following website (http://www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf).

To keep your Louisiana ***Medicaid number*** active, you must complete an enrollment packet (Sample Attached). The enrollment packet requires completion of two forms: 1) Basic Enrollment Packet and 2) Provider-type Specific Packet for your discipline. The enrollment packet can be found at www.lamedicaid.com. If you have any questions, contact the Unisys Provider Relations department at 1-877-598-8753.

LICENSURE

At this point in your training, you should already have your own DEA number, but if you do not, you need to apply now. You should apply for your DEA (www.deadiversion.usdoj.gov) and CDS (www.labp.com) by March, at the latest.

- First, apply for your state CDS license. Cost: $45 and must be mailed.
- Once you have been approved for your state license, you can apply for a Federal DEA number. Complete Form 224. Cost: $551 - payable by credit card online, otherwise mail in your completed form with a check.
- *These two steps can be done simultaneously.*
  ****Many employers will not finalize your credentials without these licenses.***

LONG TERM DISABILITY INSURANCE

The Hartford is the long term disability insurance company provided by the LSU GME office for all house officers. When completing your residency, you are eligible to continue your long term disability coverage (See the attached Hartford Continuation of coverage/conversion packet). You have to mail in the application within 31 days after your last day of employment. Once you complete the packet, please forward to the GME office, 2020 Gravier Street Suite 602, New Orleans, LA 70112 for further processing.

CREDENTIALING AND VERIFICATIONS

Be *proactive and involved* with your credentialing process. You will need all of this documentation easily accessible for your credentialing process. Start collecting copies of all of these important documents: 1) licenses (making sure all licenses are current); 2) diplomas or completion certificates; 3) Certifications (e.g., ACLS, BLS); 4) letters of recommendation; and 5) health requirement documentation including an updated TB test. In addition, if your program requires procedure logs, keep your tracking current. Be sure to retain a copy of all of these documents for your own files.

Verifications: Please provide your new employer and other parties (e.g., insurance companies) with the attached memo regarding the LSU training verification process. Your coordinator will upload your verification form to FCVS/Federation of State Board Verification Services automatically for each PGY year you complete at LSU.

MALPRACTICE INSURANCE and MOONLIGHTING

Louisiana Medical Mutual Insurance Company (LAMMICO) is mutual insurance company providing professional liability products and service to all eligible physicians staying to practice in Louisiana. The application process can take 2-3 months. Visit www.lammico.com for more information. If you are moonlighting, makes sure you have "tail coverage" through an independent company.

HEALTH INSURANCE and RETIREMENT

See the attached summary of details from the LSUHSC Human Resource Department.

If you are leaving the State of Louisiana, you will need to address the following topics:

NPI and MEDICAID NUMBERS

To modify your NPI registration, you must go to the National Plan & Provider Enumeration System (https://nppes.cms.hhs.gov). Please update your new home and office address and update your registration with a new Taxonomy Code corresponding to the license that you now hold and practice type. If you originally applied for your NPI online and still know your login information, you can update it online. If you no longer have your NPI login information, complete the application available at the following website (http://www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf).

Your **Louisiana Medicaid number** will be automatically cancelled upon your graduation by the LSU GME Office.

LICENSURE

If you do not have one already, you should apply for your new state DEA (www.deadiversion.usdoj.gov) and CDS (www.labp.com) by March, at the latest. State licensure can take approximately 6 months to a year to complete, so apply early. (e.g., Texas State licensure process may take up to a year to complete).

- First, apply for your state CDS license. Cost: $20 and must be mailed.
- Once you have been approved for your state license, you can apply for a Federal DEA number. Complete Form 224. Cost: $551 – payable by credit card online, otherwise mail in your completed form with a check.
- *These two steps can be done at the simultaneously.*

****Many employers will not finalize your credentials without these licenses***

LONG TERM DISABILITY INSURANCE

The Hartford is the long term disability insurance company provided by the LSU GME office for all house officers. When completing your residency, you are eligible to continue your long term disability coverage (See the attached Hartford Continuation of coverage/conversion packet). You have to mail in the application within 31 days after your last day of employment. Once you complete the packet, please forward to the GME office, 2020 Gravier Street Suite 602, New Orleans, LA 70112 for further processing.

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Verifications: Please provide your new employer and other parties (e.g., insurance companies) with the attached memo regarding the LSU training verification process. Your coordinator will upload your verification form to FCVS/Federation of State Board Verification Services automatically for each PGY year you complete at LSU.

HEALTH INSURANCE and RETIREMENT

See the attached summary of details from the LSUHSC Human Resource Department.

NPI/MEDICAID

National Provider Identifier Standard (NPI)

Overview

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

As outlined in the Federal Regulation, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

More detailed information is available on the pages listed in the left hand column of this page.

NPI Frequently Asked Questions (FAQs)

NPI FAQs are posted on the CMS website and continue to be updated as new information is available. To view these FAQs, see the "Related Links Inside CMS" section below. To find the latest FAQs, click on the arrows next to "Date Updated".

Downloads

NPI Final Rule [PDF, 249KB]

Dear Provider Letter from CMS Administrator [PDF, 125KB]

Related Links Inside CMS

HIPAA - General Information

Apply Now - National Plan and Provider Enumeration System (NPPES)

NPI Frequently Asked Questions (FAQs)

Related Links Outside CMS

Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative

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Help with File Formats and Plug-Ins

Submit Feedback

National Provider Identifier Standard (NPI)

- Overview
- CMS Communications
- **How to Apply**
- Educational Resources
- Enumeration Reports
- Medicare NPI Implementation
- Data Dissemination
- EFI
- National Provider Identifier (NPI) Email Updates

How to Apply

Health care providers can apply for NPIs in one of three ways:

- For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply log onto the National Plan and Provider Enumeration System (NPPES) and apply on line (see Related links inside CMS)
- Health care providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so
- Health care providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. This form is now available for download from the CMS website or by request from the NPI Enumerator. Health care providers who wish to obtain a copy of this form from the NPI Enumerator may do so in any of these ways:
  - Phone: 1-800-465-3203 or TTY 1-800-692-2326
  - E-mail: customerservice@npienumerator.com
  - Mail:
    NPI Enumerator
    P.O. Box 6059
    Fargo, ND 58108-6059

View the "NPPES Enhancements and Updates" document in the Downloads section below to learn the latest changes to the NPPES as of September 13, 2009.

Downloads

NPPES Enhancements and Updates Effective 9-13-09 [PDF 40KB]

CMS-10114 NPI Application/Update Form [PDF, 76KB]

Related Links Inside CMS

Apply Now - National Plan and Provider Enumeration System (NPPES)

NPI Frequently Asked Questions (FAQs)

Related Links Outside CMS

There are no Related Links Outside CMS

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Help with File Formats and Plug-Ins

Submit Feedback

NPPES
National Plan & Provider Enumeration System

Home Help

NPI Registry Search

Please enter data for at least one of the following fields. If searching on Practice Address State, you must enter data for at least one other field. To perform a wild card search, at least two characters must be entered before the "*". For example, to search for data beginning with "Ch", enter "Ch*". Wild card searches are only available on the Provider First Name, Provider Last Name and Practice Address City fields.

Information in the NPI Registry is updated daily.

NPI	
Provider First Name	
Provider Last Name	
Practice Address City	
Practice Address State	
Practice Address Zip	

Search Reset Back

Form Approved
OMB No. 0938-0931

NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

Please PRINT or TYPE all information so it is legible. Use only blue or black ink. Do not use pencil. Failure to provide complete and accurate information may cause your application to be returned and delay processing of your application. In addition, you may experience problems being recognized by insurers if the records in their systems do not match the information you have furnished on this form. Information submitted on this application (except for Social Security Number, IRS Individual Taxpayer Identification Number, and Date of Birth) may be made available on the internet.

SECTION 1 – BASIC INFORMATION

A. Reason For Submittal Of This Form (Check the appropriate box)

1. ❑ Initial Application
2. ❑ Change of Information (See instructions)
   NPI:_____
   ❑ Add Information
   ❑ Replace Information
3. ❑ Deactivation (See Instructions)
   NPI: _____
   Reason (Check one of the following)
   ❑ Death ❑ Business Dissolved
   ❑ Other, Specify: (See Instructions) _____
4. ❑ Reactivation (See Instructions)
   NPI: _____
   Reason: _____

B. Entity Type (Check only one box) (See Instructions)

1. ❑ An individual who renders health care. **(Complete Sections 2A, 3, 4A and 5 only)**
   - Is the individual a sole proprietor? (See Instructions) ❑ Yes ❑ No
2. ❑ An organization that renders health care. **(Complete Sections 2B, 3, 4B and 5 only)**
   - Is the organization a subpart? (See Instructions) ❑ Yes ❑ No
   - If yes, enter the Legal Business Name (LBN) and Taxpayer Identification Number (TIN) of the "parent" organization health care provider:
     Parent Organization LBN:_____
     Parent Organization TIN: _____

SECTION 2 – IDENTIFYING INFORMATION

A. Individuals *(includes Sole Proprietorships and Incorporated Individuals)*

1. Prefix (e.g.,Major, Mrs.)	2. First	3. Middle	4. Last
5. Suffix (e.g., Jr., Sr.)		6. Credential (e.g., M.D., D.O.)	

Other Name Information (If applicable. Use additional sheets of paper if necessary)

7. Prefix (e.g.,Major, Mrs.)	8. First	9. Middle	10. Last
11. Suffix (e.g., Jr., Sr.)		12. Credential (e.g., M.D., D.O.)	

13. Type of other Name
❑ Former Name ❑ Professional Name ❑ Other, specify: _____

14. Date of Birth (mm/dd/yyyy)	15. State of Birth (U.S. only)	16. Country of Birth (If other than U.S.)

17. Gender
❑ Male ❑ Female

18. Social Security Number (SSN)	19. IRS Individual Taxpayer Identification Number (ITIN) (See Instructions)

B. Organizations *(includes Groups, Corporations and Partnerships)*

1. Name (Legal Business Name)	2. Employer Identification Number (EIN) (Do not report an SSN in this field.)

3. Other Name (Use additional sheets of paper if necessary)

4. Type of Other Name
❑ Former Legal Business Name ❑ D/B/A Name ❑ Other (Describe) _____

SECTION 3 – BUSINESS ADDRESSES AND OTHER INFORMATION

A. Business Mailing Address Information *(Do not report your residential address unless it is also your Business Mailing Address.)*

1. Business Mailing Address Line 1 (Street Number and Name or P.O. Box)

2. Business Mailing Address Line 2 (Address Information; e.g., Suite Number)

3. Business City	4. Business State	5. ZIP+4 or Foreign Postal Code

6. Business Country Name (if outside U.S.)

7. Business Telephone Number (Include Area Code & Extension)	8. Business Fax Number (Include Area Code)

B. Business Practice Location Information *(Do not report your residential address unless it is also your Business Practice Location.)*

1. Business Primary Practice Location Address Line 1 (Street Number and Name – P.O. Boxes Not Acceptable)

2. Business Primary Practice Location Address Line 2 (Address Information; e.g., Suite Number)

3. Business City	4. Business State	5. ZIP+4 or Foreign Postal Code

6. Business Country Name (if outside U.S.)

7. Business Telephone Number (Include Area Code & Extension) (Required)	8. Business Fax Number (Include Area Code)

C. Other Provider Identification Numbers *(Use additional sheets of paper if necessary) Do not include SSN, ITIN, or EIN in this section.*

Issuer	Identification Number	State *(If applicable)*	Issuer *(For Other Number Type Only)*
Medicare UPIN			
Medicare OSCAR/Certification			
Medicare PIN			
Medicare NSC			
Medicaid			
Other, Specify:		(State is required if Medicaid number is furnished.)	

D. Provider Taxonomy Code *(Provider Type/Specialty. Enter one or more codes)* and License Number Information

Do not include SSN, ITIN, or EIN in this section.

Information on provider taxonomy codes is available at *www.wpc-edi.com/taxonomy*. Please see instructions if you plan to submit more than one taxonomy code for a Type 2 (organization) entity.

1. **Primary** Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

2. License Number (See Instructions)	3. State where issued

4. Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

5. License Number (See Instructions)	6. State where issued

7. Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

8. License Number (See Instructions)	9. State where issued

PENALTIES FOR FALSIFYING INFORMATION ON THE NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

SECTION 4 – CERTIFICATION STATEMENT

I, the undersigned, certify to the following:

- This form is being completed by, or on behalf of, a health care provider as defined at 45 CFR 160.103.
- I have read the contents of the application and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NPI Enumerator of this fact immediately.
- I authorize the NPI Enumerator to verify the information contained herein. I agree to notify the NPI Enumerator of any changes in this form within 30 days of the effective date of the change.
- I have read and understand the Penalties for Falsifying Information on the NPI Application/Update Form as printed in this application. I am aware that falsifying information will result in fines and/or imprisonment.
- I have read and understand the Privacy Act Statement.

A. Individual Practitioner's Signature

1. Applicant's Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	2. Date (mm/dd/yyyy)

B. Authorized Official's Information and Signature for the Organization

1. Prefix (e.g.,Major, Mrs.)	2. First	3. Middle	4. Last

5. Suffix (e.g., Jr., Sr.)	6. Credential (e.g., M.D., D.O.)

7. Title/Position	8. Telephone Number (Area Code & Extension)

9. Authorized Official's Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	10. Date (mm/dd/yyyy)

SECTION 5 – CONTACT PERSON

A. Contact Person's Information

❑ Check here if you are the same person identified in 2A or 4B.

If you checked the box, complete only items 8 and 9 in this section (Section 5).

1. Prefix (e.g.,Major, Mrs.)	2. First	3. Middle	4. Last

5. Suffix (e.g., Jr., Sr.)	6. Credential (e.g., M.D., D.O.)

7. Title/Position	8. E-Mail Address	9. Telephone Number

For the most efficient and fast receipt of your NPI, please use the web-based NPI process at the following address: *https://nppes.cms.hhs.gov.* NPI web is a quick and easy way for you to get your NPI.

Or send the completed signed application to:

NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

PRIVACY ACT STATEMENT

Section 1173 of the Social Security Act authorizes the adoption of a standard unique health identifier for all health care providers who conduct electronically any standard transaction adopted under 45 CFR 162. The purpose of collecting this information is to assign a standard unique health identifier, the National Provider Identifier (NPI), to each health care provider for use on standard transactions. The NPI will simplify the administrative processing of certain health information. Further, it will improve the efficiency and effectiveness of standard transactions in the Medicare and Medicaid programs and other Federal health programs and private health programs. The information collected will be entered into a new system of records called the National Provider System (NPS), HHS/HCFA/OIS No. 09-70-0008. In accordance with the NPPES Data Dissemination Notice (CMS-6060), published May 30, 2007, certain information that you furnish will be publicly disclosed. The NPPES Data Dissemination Notice can be found at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/DataDisseminationNPI.pdf.

Failure to provide complete and accurate information may cause the application to be returned and delay processing. In addition, you may experience problems being recognized by insurers if the records in their systems do not match the information you furnished on the form. (See the instructions for completing the NPI application/update form to find the information that is voluntary or mandatory.)

Information may be disclosed under specific circumstances to:

1. The entity that contracts with HHS to perform the enumeration functions, and its agents, and the NPS for the purpose of uniquely identifying and assigning NPIs to providers.
2. Entities implementing or maintaining systems and data files necessary for compliance with standards promulgated to comply with title XI, part C, of the Social Security Act.
3. A congressional office, from the record of an individual, in response to an inquiry from the congressional office made at the request of that individual.
4. Another Federal agency for use in processing research and statistical data directly related to the administration of its programs.
5. The Department of Justice, to a court or other tribunal, or to another party before such tribunal, when
   (a) HHS, or any component thereof, or
   (b) Any HHS employee in his or her official capacity; or
   (c) Any HHS employee in his or her individual capacity, where the Department of Justice (or HHS, where it is authorized to do so) has agreed to represent the employee; or
   (d) The United States or any agency thereof where HHS determines that the litigation is likely to affect HHS or any of its components is party to litigation or has an interest in such litigation, and HHS determines that the use of such records by the Department of Justice, the tribunal, or the other party is relevant and necessary to the litigation and would help in the effective representation of the governmental party or interest, provided, however, that in each case HHS determines that such disclosure is compatible with the purpose for which the records were collected.
6. An individual or organization for a research, demonstration, evaluation, or epidemiological project related to the prevention of disease or disability, the restoration or maintenance of health, or for the purposes of determining, evaluating and/or assessing cost, effectiveness, and/or the quality of health care services provided.
7. An Agency contractor for the purpose of collating, analyzing, aggregating or otherwise refining or processing records in this system, or for developing, modifying and/or manipulating automated data processing (ADP) software. Data would also be disclosed to contractors incidental to consultation, programming, operation, user assistance, or maintenance for ADP or telecommunications systems containing or supporting records in the system.
8. An agency of a State Government, or established by State law, for purposes of determining, evaluating and/or assessing cost, effectiveness, and/or quality of health care services provided in the State.
9. Another Federal or State agency
   (a) As necessary to enable such agency to fulfill a requirement of a Federal statute or regulation, or a State statute or regulation that implements a program funded in whole or in part with Federal funds.
   (b) For the purpose of identifying health care providers for debt collection under the provisions of the Debt Collection Information Act of 1996 and the Balanced Budget Act.

INSTRUCTIONS FOR COMPLETING THE NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

Please PRINT or TYPE all information so it is legible. Use only blue or black ink. Do not use pencil. Failure to provide complete and accurate information may cause your application to be returned and delay processing of your application. In addition, you may experience problems being recognized by insurers if the records in their systems do not match the information you have furnished on this form. **Please note: Social Security Number (SSN) or IRS Individual Taxpayer Identification Number (ITIN) information should only be listed in block 18 or block 19 of this form. DO NOT report SSN or ITIN information in any other section of this application form.**

This application is to be completed by, or on behalf of, a health care provider or a subpart seeking to obtain an NPI. (See 45 CFR 162.408 and 162.410 (a) (1).

SECTION 1 – BASIC INFORMATION

This section is to identify the reason for submittal of this form and the type of entity seeking to obtain an NPI.

A. Reason for Submittal of this Form

This section identifies the reason the health care provider is submitting this form. *(Required)*

1. **Initial Application**
   If applying for a NPI for the first time check box #1, and complete appropriate sections as indicated in Section 1B for your entity type.
2. **Change of Information**
   If changing information, check box #2, write your NPI in the space provided, and provide the add/replace information within the appropriate section. If you are adding information, please check the 'Add Information' box and fill out the appropriate section(s) with the information you are adding. If you are replacing information, please check the 'Replace Information' box and fill out the appropriate section(s) with the replaced information. See the instructions in Section 4, then sign and date the certification statement in Section 4A or 4B. All changes must be reported to the NPI Enumerator within 30 days of the change. It is not necessary to complete sections that are not being changed; however, please ensure that your NPI is legible and correct. Complete Section 5 so that we may contact you in the event of problems processing this form. Please note that some changes, such as a change to a health care provider's date of birth, require a photocopy of the health care provider's U.S. driver's license or birth certificate to be submitted along with the form for verification purposes.
3. **Deactivation**
   If you are deactivating the NPI, check box #3. Record the NPI you want to deactivate, indicate the reason for deactivation, and complete Section 2. Sign and date the certification statement in Section 4A or 4B, as appropriate. See instructions for Section 4. Use additional sheets of paper if necessary. Please note that deactivations due to death must be completed and signed in Section 4 by the Power of Attorney or Executor of the Will. In addition, a copy of the death certificate or obituary must accompany the completed signed form.
4. **Reactivation**
   If you are reactivating the NPI, check box #4. Record the NPI you want to reactivate, provide the reason for reactivation, and complete Section 2. Sign and date the certification statement in Section 4A or 4B, as appropriate. See instructions for Section 4. Use additional sheets of paper if necessary.

B. Entity Type

Check only one box (*Required* for initial applications)

Entity Type 1: Individuals who render health care or furnish health care to patients: e.g., physicians, dentists, nurses, chiropractors, pharmacists, physical therapists. Incorporated individuals may obtain NPIs for themselves (Entity Type 1 Individual) if they are health care providers and may obtain NPIs for their corporations (Entity Type 2 Organization). A sole proprietorship is an Entity Type 1 (Individual). (A sole proprietorship is a form of business in which one person owns all the assets of the business and is solely liable for all the debts of the business in an individual capacity. Therefore, sole proprietorships are not organization health care providers.) Note that sole proprietorships may obtain only one NPI. Sole proprietorships must report their SSNs (not EINs even if they have EINs). Virtually any health care provider could be a sole proprietorship, including most of the examples listed in Entity Type 2.

Entity Type 2: Organizations that render health care or furnish health care supplies to patients; e.g., hospitals, home health agencies, ambulance companies, group practices, health maintenance organizations, durable medical equipment suppliers, pharmacies. Solely owned corporations that are health care providers obtain NPIs as Entity Type 2. If the organization is a subpart, check yes and furnish the Legal Business Name (LBN) and Taxpayer Identification Number (TIN) of the "parent" organization health care provider.(A subpart is a component of an organization health care provider. A subpart may be a different location or may furnish a different type of health care than the organization health care provider. For ease of reference, we refer to that organization health care provider as the "parent".)

SECTION 2 – IDENTIFYING INFORMATION

A. Individual *(includes Sole Proprietorships and Incorporated Individuals)*

NOTE: An individual may obtain only one NPI, regardless of the number of taxonomies (specialties), licenses, or business practice locations he/she may possess. SSN or ITIN information should only be listed in block 18 or block 19, respectively, of this form. DO NOT report SSN and ITIN information in any other section of this form.

A sole proprietorship is an individual.

Name Information

1–6. Provide your full legal name. (Required first and last name) Do not use initials or abbreviations. If you furnish your social security number in block 18, this name must match the name on file with the Social Security Administration (SSA). In addition, the date of birth must match that on file with SSA. You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

Other name information *(Use additional sheets of paper if necessary)*

7–12. If you have used another name, including a maiden name, supply that "Other Name" in this area. (Optional) You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

13. Mark the check box to indicate the type of "Other Name" you used. (Required if 7-12 are completed)

14–16. Provide the date *(Required)*, State *(Required)*, and country *(Required, if other than U.S.)* of your birth. Do not use abbreviations other than United States (U.S.).

17. Indicate your gender. *(Required)*

18. Furnish your Social Security Number (SSN) for purposes of unique identification. *(Optional)* If you furnish your SSN, this name must match the name and date of birth on file with the Social Security Administration (SSA). If you do not furnish your SSN, processing of your application may be delayed because of the difficulty of verifying your identity via other means; you may also have difficulty establishing your proper identity with insurers from which you receive payments. If you are not eligible for an SSN, see item #19. **If you do not furnish your SSN, you must furnish 2 proofs of identity with this application form: passport, birth certificate, a photocopy of your U.S. driver's license, State issued identification, or information requested in item #19.**

19. If you do not qualify for an SSN, furnish your IRS Individual Taxpayer Identification Number (ITIN) along with a photocopy of your U.S. driver's license, State issued ID, birth certificate or passport. **You may not report an ITIN if you have an SSN. Do not enter an Employer Identification Number (EIN) in the ITIN field. Note: Your passport, birth certificate, photocopy of the U.S. driver's license or State issued identification must accompany your ITIN. If you do not furnish the information requested in blocks 18 or 19, you must furnish 2 proofs of identity with this application form: passport, birth certificate, a photocopy of your U.S. driver's license or State issued identification.** Examples of individuals who need ITINs include:
    - Non-resident alien filing a U.S. tax return and not eligible for an SSN;
    - U.S. resident alien *(based on days present in the United States)* filing a U.S. tax return and not eligible for an SSN;
    - Dependent or spouse of a U.S. citizen/resident alien; and
    - Dependent or spouse of a non-resident alien visa holder.

B. Organizations *(Includes Groups, Corporations and Partnerships)*

1–2. Provide your organization's or group's name *(legal business name used to file tax returns with the IRS)* and Employer Identification Number *(assigned by the IRS) (Required)*

3. If your organization or group uses or previously used another name, supply that "Other Name" in this area. *(Optional)* Use additional sheets of paper if necessary.

4. Mark the check box to indicate the type of "Other Name" used by your organization. *(D/B/A Name=Doing Business As Name.) (Required if 3 is completed.)*

NOTE: A sole proprietorship does not complete this section; he/she completes Section A.

SECTION 3 – ADDRESSES AND OTHER INFORMATION

A. Business Mailing Address Information *(Required)*

This information will assist us in contacting you with any questions we may have regarding your application for an NPI or with other information regarding NPI. You must provide an address and telephone number where we can contact you directly to resolve any issues that may arise during our review of your application. Do not report your residential address in this section unless it is also your business mailing address.

B. Business Practice Location Information *(Required)*

Provide information on the address of your primary practice location. If you have more than one practice location, select one as the "primary" location. Do not furnish information about additional locations on additional sheets of paper. Do not report your residential address in this section unless it is also your business practice location.

C. Other Provider Identification Numbers *(Optional)*

To assist health plans in matching your NPI to your existing health plan assigned identification number(s), you may wish to list the provider identification number(s) you currently use that were assigned to you by health plans. If you do not have such numbers, you are not required to obtain them in order to be assigned an NPI. Organizations should only furnish other provider identification numbers that belong to the organization; do not list identification numbers that belong to health care providers who are individuals who work for the Organizations. DO NOT report SSN, ITIN, or EIN information in this section of the form.

D. Provider Taxonomy Code *(Provider Type/Specialty) (Required)*

Provide your 10-digit taxonomy code. You must select a primary taxonomy code in order to facilitate aggregate reporting of providers by classification/specialization. If you need additional taxonomy codes to describe your type/classification/specialization, you may select additional codes. Information on taxonomy codes is available at www.wpc-edi.com/taxonomy.

Furnish the provider's health care license, registration, or certificate number(s) (if applicable). If issued by a State, show the State that issued the license/certificate. The following individual practitioners are required to submit a license number *(If you are one of the following and do not have a license or certificate, you must enclose a letter to the Enumerator explaining why not)*:

Certified Registered Nurse Anesthetist	Clinical Psychologist	Nurse Practitioner	Physician/Osteopath
Chiropractor	Dentist	Optometrist	Podiatrist
Clinical Nurse Specialist	Licensed Nurse	Pharmacist	Registered Nurse

You may use the same license, registration, or certification number for multiple taxonomies; e.g., if you are a physician with several different specialties.

NOTE: A health care provider that is an organization, such as a hospital, may obtain an NPI for itself and for any subparts that it determines need to be assigned NPIs. In some cases, the subparts have Provider Taxonomy Codes that may be different from that of the hospital and of each other, and each subpart may require separate licensing by the State (e.g., General Acute Care Hospital and Psychiatric Unit). If the organization provider chooses to include these multiple Provider Taxonomy Codes in a request for a single NPI, and later determines that the subparts should have been assigned their own NPIs with their associated Provider Taxonomy Codes, the organization provider must delete from its NPPES record any Provider Taxonomy Codes that belong to the subparts who will be obtaining their own NPIs. The organization provider must do this by initiating the Change of Information option on this form.

SECTION 4 – CERTIFICATION STATEMENT *(Required)*

This section is intended for the applicant to attest that he/she is aware of the requirements that must be met and maintained in order to obtain and retain an NPI. This section also requires the signature and date of signature of the "Individual" who is the type 1 provider, or the "Authorized Official" of the type 2 organization who can legally bind the provider to the laws and regulations relating to the NPI. See below to determine who within the provider qualifies as an Authorized Official. Review these requirements carefully.

Authorized Official's Information and Signature for the Organization

By his/her signature, the authorized official binds the provider/supplier to all of the requirements listed in the Certification Statement and acknowledges that the provider may be denied a National Provider Identifier if any requirements are not met. This section is intended for organizations; not health care providers who are individuals. All signatures must be original. Stamps, faxed or photocopied signatures are unacceptable. You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

An authorized official is an appointed official with the legal authority to make changes and/or updates to the provider's status (e.g., change of address, etc.) and to commit the provider to fully abide by the laws and regulations relating to the National Provider Identifier. The authorized official must be a general partner, chairman of the board, chief financial officer, chief executive officer, direct owner of 5 percent or more of the provider being enumerated, or must hold a position of similar status and authority within the provider.

Only the authorized official(s) has the authority to sign the application on behalf of the provider.

By signing this application for the National Provider Identifier, the authorized official agrees to immediately notify the NPI Enumerator if any information in the application is not true, correct, or complete. In addition, the authorized official, by his/her signature, agrees to notify the NPI Enumerator of any changes to the information contained in this form within 30 days of the effective date of the change.

SECTION 5 – CONTACT PERSON *(If the contact person is the same person identified in 2A or 4B, complete items 8 & 9 in this section.) (Required)*

To assist in the timely processing of the NPI application, provide the name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application. The contact person can be the health care provider. The contact person will receive the NPI notification once the health care provider has been assigned an NPI. Please note that if a contact person is not provided, all questions about this application will be directed to the health care provider named in Section 2 or the authorized official named in Section 4, as appropriate. You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

LICENSURE

CDS/DEA

Louisiana Board of Pharmacy
5615 Corporate Blvd. Suite 8-E
Baton Rouge, La. 70808
Phone: (225) 925-6496
Fax: (225) 925-6499

Louisiana Board of Pharmacy

5615 Corporate Blvd., Suite 8-E
Baton Rouge, Louisiana 70808-2537

Telephone (225) 925-6496
Web address: www.labp.com
Email: labp@labp.com

APPLICATION FOR A LOUISIANA CONTROLLED DANGEROUS SUBSTANCES (CDS) LICENSE

APPLICATION INSTRUCTIONS

Enclosed is an Application for a Louisiana Controlled Dangerous Substance (CDS) License.

Louisiana CDS Licenses are site-specific for the location where the controlled dangerous substances are utilized. If you have more than one practice location where Controlled Dangerous Substances are maintained then you must submit a separate application for each location.

Original completed application must be **mailed** to the Louisiana Board of Pharmacy at the address above with the correct fee. **Faxed applications will not be accepted.**

SECTION 1 – REASON FOR APPLICATION

- Select the reason for the application.
- For renewals, enter the existing CDS number.

SECTION 2 – REGISTRANT INFORMATION

Post office boxes cannot be accepted as practice location.

Business Applicants:

- Enter the business or facility name and tax ID number of the business.
- Enter the business and fax numbers of the facility.
- Enter the state Board license information.
    - Enter the applicable Board license number and expiration date (this applies to all applicants who are licensed by a licensing Board) and attach a copy of the Board license.
    - This office cannot accept interim, provisional, or temporary licenses.
    - If you are a facility applying for a CDS license, enter the facility's license number that is issued by the Health Standards Section of the Department of Health and Hospitals. If your facility does not have a license number then enter the license number of the facility's physician medical director.
- DEA registration information
    - Enter this number if you already hold a DEA registration number for Louisiana and are seeking reinstatement or if you currently hold a valid DEA registration number from another state and the name of the state in which it was issued. If you have never held a DEA registration number before, you may leave the space blank or write "pending" in the space.
    - Note: All applicants must apply for a new DEA registration number if you are moving to Louisiana from another state.
- Enter the complete physical address of the practice location.
- All facility controlled substance licenses are to be to the attention of the chief pharmacist, consultant pharmacist or physician medical director. This is the same person that must sign the application.

Practitioners:

- Enter the registrant's name and social security number.
- Enter the business and fax numbers of the registrant.
- Enter the state Board license information.
    - Enter the applicable Board license number and expiration date (this applies to all applicants who are licensed by a licensing Board) and attach a copy of the Board license.
    - This office cannot accept interim, provisional, or temporary licenses.
    - All optometrists, physician's assistants, medical psychologists, and APRN's **must** submit a copy of both their respective Board's license **and** their Limited Prescriptive and Distributive Authority for Controlled Dangerous Substances authorization letter.

- DEA registration information.
    - Enter this number if you already hold a DEA registration number for Louisiana and are seeking reinstatement or if you currently hold a valid DEA registration number from another state and the name of the state in which it was issued. If you have never held a DEA registration number before, you may leave the space blank or write "pending" in the space.
    - Note: All applicants must apply for a new DEA registration number if you are moving to Louisiana from another state.
- Enter the complete physical address of the practice location (practitioners may prescribe for their patients from anywhere within the state.)

Sales Representatives:

- Enter the name of the sales representative and the name of the company.
- Enter the business and fax numbers of the registrant.
- Enter the applicable Board license number and expiration date (this applies to all applicants who are licensed by a licensing Board) and attach a copy of the Board license.
- DEA registration information.
    - Enter this number if you already hold a DEA registration number for Louisiana and are seeking reinstatement or if you currently hold a valid DEA registration number from another state and the name of the state in which it was issued. If you have never held a DEA registration number before, you may leave the space blank or write "pending" in the space.
    - Note: All applicants must apply for a new DEA registration number if you are moving to Louisiana from another state.
- Enter the physical address of the company's headquarters.
- You must submit a letter of verification of employment and authorization executed by the manufacturer / distributor you represent.

SECTION 3 – CLASSIFICATION OF LICENSE

- Check the appropriate class of license being applied for and submit the fee amount listed with the completed application.
- All facilities must submit a CDS Protocol Form with their application.

SECTION 4 – DRUG SCHEDULES

- Enter the schedules that you are requesting to be licensed for by checking the appropriate boxes in the section.
- The only persons who may apply for Schedule I drugs are researchers, analytical labs, law enforcement agencies, and K-9 trainers.

SECTION 5 – CERTIFICATION STATEMENTS

- All applicants must read and complete this section to be licensed.
- If you are a business applicant, answer the question for "Business Applicants."
- If you are an individual applicant, answer the question for "Individual Applicants."
- For renewals only – Answer the question for "Renewals Only" and enter the expiration date of the Board license held by the applicant.

SECTION 6 – APPLICANT'S SIGNATURE

- Read the statement, then sign and date the appropriate line.

CONTROLLED DANGEROUS SUBSTANCES LICENSES NOT RENEWED WITHIN 30 DAYS AFTER EXPIRATION ARE REPORTED TO THE FEDERAL DRUG ENFORCEMENT ADMINISTRATION.

CHANGES: Licensees are required to inform the Board of all changes of name, physical practice location and mailing address. Notification must include a fee of $5.00 for printing a new license.

Louisiana Board of Pharmacy

5615 Corporate Blvd., Suite 8-E
Baton Rouge, Louisiana 70808-2537

Telephone (225) 925-6496
Web address: www.labp.com
Email: labp@labp.com

APPLICATION FOR A LOUISIANA CONTROLLED DANGEROUS SUBSTANCES (CDS) LICENSE

Falsification of any information in this application or other required documentation shall subject the applicant to imprisonment for not more than 5 years, a fine of not more than $5,000, or both (La R.S. 40:971.B.)
THE BOARD MAY SUSPEND OR REVOKE THIS LICENSE FOR CAUSE.

To avoid processing delays, please refer to instruction sheet before completing this application.

Mail completed application, directed specifically to "CDS Program", at the address noted above. Faxed applications will not be accepted.

FOR BOARD OFFICE USE ONLY
CK#_____ AMT_____
Date application rec'd _____
License #_____ Date Issued: _____

SECTION 1 – Reason for Application

_____ New CDS License
_____ Renewal or Reinstatement of Existing CDS License #_____ Add $10 to renewal fee if license has been expired for more than 30 days

SECTION 2 – Registrant Information

Business Applicants:	Full Business or Facility Name		
	Taxpayer ID # __ __ - __ __ __ __ __ __ __		
Individual Applicants:	Last Name	First Name	Middle Initial
	Social Security # __ __ __ - __ __ - __ __ __ __		
Business Phone	Business Fax	Home Phone	
LA State Board License # _____ LA State Board License Expiration Date (mm-dd-yyyy) _____	DEA Registration # _____ DEA Registration Expiration Date (mm-dd-yyyy) _____		

Enter Physical Address of Practice Location (Do not enter a P. O. Box)	Mailing Address (If different than physical address)	Home Address
Address Line 1	Address Line 1	Address Line 1
Address Line 2	Address Line 2	Address Line 2
City	City	City
State	State	State
Zip	Zip	Zip

For Businesses, enter name of Chief Pharmacist, Consultant Pharmacist or Physician Medical Director (must sign application)

SECTION 3 – Classification of License (Select Only One)
Submit a check or money order payable to Louisiana Board of Pharmacy in the required amount

The following applicants must submit one (1) copy of LA Controlled Dangerous Substances Protocol Form with the application. The form may be printed from the website at www.labp.com.		
_____ Ambulatory Surgical Center ($50)	_____ Hospital ($50)	_____ APRN ($45)*
_____ Animal Euthanasia Tech. ($20)	_____ Laboratory ($20)	_____ Dentist ($45)*
_____ Clinic / Rural Health Clinic / Emerg. Ctr ($50)	_____ Manufacturer ($100)	_____ Med. Psych. ($45)*
_____ Dialysis Center ($20)	_____ Narcotic Treatment Center ($50)	_____ Optometrist ($45)*
_____ Drug Detection – Canine ($30)	_____ Researcher ($30)	_____ Physician ($45)*
_____ EMS ($20)	_____ Sales Representative ($20)	_____ Physician Asst ($45)*
_____ Other _____ ($20)	_____ Wholesaler / Distributor ($50)	_____ Podiatrist ($45)*
		_____ Veterinarian ($20)

* Fee includes Prescription Monitoring Program (PMP) fee as authorized by La. R.S. 40:1013.

SECTION 4 – Drug Schedules
Check ALL applicable Schedules to be handled. License will be issued for those schedules checked ONLY.

_____ Schedule I (Experimental)	_____ Schedule III	_____ Schedule V
_____ Schedule II	_____ Schedule III-N (Non-narcotic)	
_____ Schedule II-N (Non-narcotic)	_____ Schedule IV	

SECTION 5 – All registrants must answer the following:
If the answer to either of the first two questions is "YES," submit a detailed statement including all circumstances along with this application.

Business Applicants:	If the applicant is a corporation, association, or partnership has any officer, partner, stockholder or proprietor been convicted of a felony in connection with controlled substances under any State of Federal Law, or ever surrendered or had a State or Federal License revoked, suspended, or denied?	_____ **Yes** _____ **No**
Individual Applicants:	Has the applicant ever been convicted of a felony in connection with controlled substances under any State or Federal Law, or ever surrendered or had a State or Federal controlled dangerous substance or practitioner's license revoked, suspended, or denied?	_____ **Yes** _____ **No**
If Application is for Renewal:	I certify that I have a valid practitioner's license from the appropriate Board of competent jurisdiction that expires on the following date: Expiration Date: _____ / _____ / 20_____	_____ **Yes** _____ **No**

SECTION 6 – Applicant's Signature

To the Louisiana Board of Pharmacy: I hereby make application for a license to manufacture, and/or distribute, and/or dispense, and/or prescribe, and/or conduct research with Controlled Dangerous Substances, as indicated above, complying with the requirements of Title 40, Part X Louisiana Revised Statute 1950 (Amended) Uniform Controlled Dangerous Substances Law, and the Rules and Regulations of the Agency adopted in accordance with said statute. It is further agreed that said establishments or offices shall be open to inspection by the Louisiana Board of Pharmacy, its agent or designee for the inspection of controlled drugs and their storage, handling and distribution.

Business Applicants:	Original Signature of Authorized Individual Identified in Section 2	Date _____ / _____ / 20_____
Individual Applicants:	Original Signature of Applicant	Date _____ / _____ / 20_____

U.S. Department of Justice Drug Enforcement Administration

Office of Diversion Control

Home
Registration
Reporting
Info & Legal Resources
Inside Diversion Control

Drug Registration > ODWIF

Email Address

Register

Online Registration
New Renew
Modify
Duplicate Validation

Registration Applications

Office of Diversion Control Web Interactive Forms (ODWIF)

NEW APPLICATIONS

Begin Application Process	Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner, Manufacturer, Distributor, Researcher, Analytical Laboratory, Importer, Exporter, Narcotic Treatment Program, Domestic Chemical

MINIMUM ON-LINE REQUIREMENTS

The DEA Forms listed below are for those applying to DEA for a controlled substance registration. Data will be entered through a **secure connection** to the ODWIF online web application system. Your **web browser must support 128-bit encryption.**

You will need to have the following information handy in order to complete the form:

- Tax ID number and/or Social Security Number
- State Controlled Substance Registration Information
- State Medical License Information
- Credit Card (VISA, MasterCard, Discover or American Express)

The ODWIF system can only process credit card transactions at this time. If you are paying by check, you will need to use the PDF version of the form, then print and mail the form to the address listed on the form.

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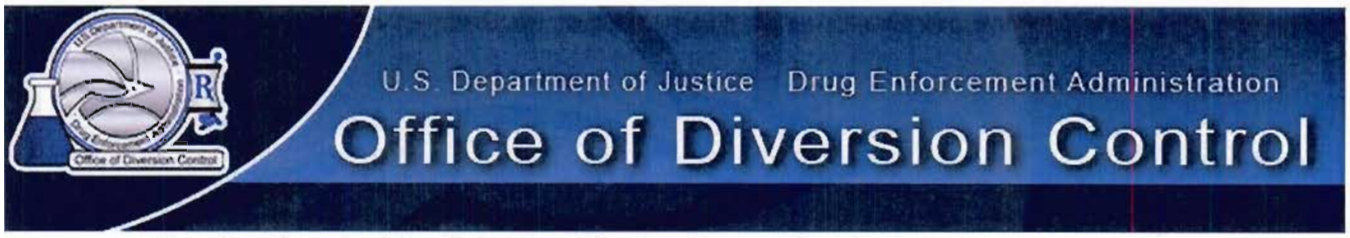
Drug Enforcement Administration Home

Home | Registration | Reporting | Info & Legal Resources | Inside Diversion Control | Privacy Statement



Application for Registration Under Controlled Substance Act of 1970 (New Applicants Only)

Application fees are not refundable.

This on-line version of the DEA registration application has **Six (6)** main sections. Please have the following information available **before** you begin the application:

Section 1. Personal/Business Information If you are applying for an Individual Registration (Practitioner, MLP, Researcher) you are required to provide your Full Name, Address, Social Security Number, and Phone Number. If you are applying for a Business Registration, you are required to provide the Name of the Business, Address, Tax ID, and Phone Number.
Section 2. Activity - Business Activity and Drug Schedule information.
Section 3. State License(s) - Information pertaining to current and pending state controlled substance licenses/registrations.
Section 4. Background Information - Information pertaining to controlled substances in the applicant's background.
Section 5. Payment - Payment, via this on-line application, must be made with a Visa or MasterCard, American Express, or Discover.
Section 6. Confirmation - Applicants will confirm the entered information, make corrections if needed, and electronically submit the application and a submission confirmation will be presented. Applicants will be able to print copies for their records.

In **addition** - Certain registrants for forms 225 and 510 will need to provide specific drug codes and/or chemical codes related to their operations.

WARNING: Section 843(a)(4)(A) of Title 21, United States Code, states that any person who knowingly or intentionally furnishes false or fraudulent information in the application is subject to imprisonment for not more than four years, a fine of not more that $30,000.00 or both.

Select Your Business Category

- (●) Form 224 - Practitioners(MD,DO,DDS,DMD,DVM,DPM), Pharmacies, Hospitals/Clinics, Teaching Institutions
- ( ) Form 225 - Manufacturers, Import/Export, Distributors, Researchers, Dog Handlers, Labs
- ( ) Form 510 - Chemical: Manufacturers, Import/Export, Distributors
- ( ) Form 363 - Treatment Clinics

Applying for a registration with the wrong Business Category/Activity will cause either delay in processing your application or the withdrawal of your application. If you are not certain of your Business Category/Activity, please contact DEA Customer Service at 1-800-882-9539.

Select One Business Activity

- Please Select -

Please do not use your browser's BACK and FORWARD buttons while navigating this form.

Begin

--Cancel--

DEA Privacy Policy

CREDENTIALING & VERIFICATION OF TRAINING

LSU Health Sciences Center
NEW ORLEANS
School of Medicine
Office of Medical Education

School of Medicine
School of Dentistry
School of Nursing
School of Allied Health Professions
School of Graduate Studies
School of Public Health

January 5, 2010

Please take note of our new Graduate Medical Education fax number for all training verifications. This fax number is linked to a fax to email machine so all verifications can be handled more efficiently.

Medical degrees, internship, residency and fellowship verifications can be faxed to ***504-568-3332***. Please include the following information on the verification:

- **Full name** of applicant
- **Dates** of training
- **Type** of training (MD, internship, residency, fellowship, staff)
- **Department/specialty** in which training was completed
- **City** in which the training was completed. (New Orleans, Shreveport, Lafayette, Baton Rouge)
- **Signed release**

The above information is needed to allow for a 3-5 day turnaround for the verification to be completed. For those verifications for graduates in the 1960's, 70's and 80's, please allow 20-30 days. All verifications are completed by individual departments.

Thank you,

Kim Cannon
GME Coordinator
kcanno@lsuhsc.edu
504-568-2468 (Phone)

LONG TERM DISABILITY

Hartford conversion info

Notice of Continuation of Coverage

As a terminated employee – or as an active employee – losing coverage or a portion of coverage under your employer's Group plan, you may be eligible to continue all or a portion of that coverage without submitting evidence of good health. Potential options are explained below. The specific options available to you are based on the provisions as defined in the Group plan. Included with this notice is a form you can submit to obtain additional information. You will receive a personalized quote, details on the specific coverage available to you, and the necessary forms to enroll.

Long Term Disability (LTD) Conversion

You may be eligible to convert coverage you had in effect under your Employer's Group Long Term Disability (LTD) plan to a Group Disability Conversion policy provided your group coverage was in effect for at least one year. You also cannot be disabled at the time of your application for an LTD conversion policy and you cannot convert LTD coverage if you are retiring, regardless of your age. LTD conversion is not available for dependents. The benefit amount payable under the LTD conversion policy is 60% of your monthly earnings at the time your Group coverage ended or the amount provided under the LTD group plan, whichever is less, up to a monthly maximum of $5,000, subject to offsets for other income benefits. A 6-month elimination period applies. LTD conversion is not available if the group plan is terminating. **A one time administrative enrollment fee will apply and is added to your first quarterly premium. Premiums for a Group Disability Conversion policy are higher than your Employer Group plan rates and increase every 5 years (years in which your age on your birthday ends in 5 or 0).**

****

Attached is a form that contains additional information about continuing coverage. You can use this to request a quote and the necessary forms to enroll.

Please note that there is a designated timeframe during which you can exercise your coverage continuation options. To continue coverage, **you must mail or fax this form to request information within 15 days from the date of this notice or 31 days from your group coverage termination date, whichever is later. Under no circumstances, however, will continuation of coverage be available beyond 91 days from your group coverage termination date. Any issues regarding late notification by your employer must be addressed with the employer.**

If you have questions about this information, your eligibility, or the status of any request you have submitted, please call a representative at **1-877-320-0484.**

The Hartford, Portability and Conversion Unit
P.O. Box 248108
Cleveland, OH 44124-8108

Fax 1-440-646-9339

Frequently Asked Questions

Q: If I request a quote, how does Hartford determine the amount of coverage to quote?
A: Hartford will contact your employer to obtain the amount of coverage you had in effect under the group plan. The quote is based on this amount as well as applicable plan provisions.

Q: If I receive a quote for coverage, does this mean I qualify for the coverage amount quoted?
A: The amount quoted is not a guarantee that a policy will be issued in that amount. Upon receipt of your application for coverage, Hartford will perform an eligibility review to determine that the amount of coverage you have requested can be granted based on the coverage you had in effect under the group plan as well as plan provisions.

Q: What is my policy effective date?
A: The effective date of an LTD Conversion policy is the day following the group coverage termination date.

Q: If my application for coverage is not approved by the effective date, am I still covered?
A: Yes, if your application is approved the effective date of your policy will be retroactive to the date indicated above.

Q: I understand that there is no medical underwriting or physical exam required but can I still be denied for coverage?
A: Your request for coverage can be denied if you do not meet the timeliness requirement. You must mail or fax this form to request information within 15 days from the date of this notice or 31 days from your group coverage termination date, whichever is later. Under no circumstances will continuation of coverage be available beyond 91 days from your group coverage termination date. Coverage can also be denied if it exceeds the amount you had in effect under your employer's Group plan or if it does not align with you employer's plan provisions. In addition, any request for coverage that is not available under your employer's Group plan will also be denied.

Q: If I start to work for a new employer and obtain coverage under that employer's Group plan, will that Group coverage impact any conversion or portability policy that I may have purchased?
A: If you obtain coverage under a new employer's Group plan, your portability or conversion policy will remain in effect provided you continue to pay the required premiums. However, benefits under conversion policies may be affected by the amount of your other coverage.

Notice of Continuation of Coverage

Employer: LSU HEALTH SCIENCE CENTER Policy #: 675955

The following information is to be completed by Employer or Employer Representative

Employee Name:_____ Employee ID#:_____ Date:_____

Last Day Worked (or date employee is no longer in an eligible class):_____

Date of Group Coverage Termination:_____ Termination Reason:_____

Signature_____ Print Name_____

Email Address_____ Telephone_____

The rates for LTD Conversion will be higher than your employer Group plan rates. LTD conversion rates increase every 5 years (years in which your age on your birthday ends in 5 or 0) and also require a one-time $25 enrollment fee which is added to the first quarterly premium.

LTD Conversion is quoted and billed quarterly.

Employee: To request specific rates and enrollment information, please complete the information below and mail or fax this entire page to:

The Hartford, Portability and Conversion Unit, P.O. Box 248108, Cleveland, OH 44124-8108
Fax 440-646-9339, Phone 877-320-0484

Yes, I am interested in receiving the information checked below.

☐ LTD Conversion Quote

Please print the following information:

Name:_____ Date of Birth:_____

Social Security # **(indicate last 4 digits only)**:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Telephone Number:_____ Email:_____

I understand that I have only 31 days from the date of my group coverage termination OR 15 days from the date of this notice, whichever is later, to complete and submit this form to The Hartford. In no event, however, will my eligibility to continue coverage exceed 91 days from my group coverage termination date.

_____ _____

Signature (required) **Date**

MALPRACTICE

INSURANCE & MOONLIGHTING

LAMMICO

Why Choose LAMMICO | About Us | Members-Only | Insurance Products & Services | Risk Management Services | Physician Advocacy | Publications

Why Choose LAMMICO

GO

- Consent to Settle
- Physician Advocacy
- Financially Secure Company
- Commitment to Louisiana
- Risk Management
- Personalized Claims Handling
- Aggressive Legal Defense
- Med Mal 101

Med Mal 101

What is medical professional liability insurance?

Medical malpractice insurance covers physicians and other health care professionals in the medical field for liability claims arising from their treatment of patients.

Back to Top

What is the Louisiana Medical Malpractice Act?

The Medical Malpractice Act is a Louisiana statute passed in 1975 that: 1) capped damages in medical malpractice cases at $500,000, 2) created the Patient's Compensation Fund (PCF) which provides for the payment of claims above $100,000 up to the $500,000 cap and for the payment of unlimited medical expenses for injured patients over the course of their lifetime, and 3) established the medical review panel (MRP) process which provides the claimant an opinion on the medical care by three health care providers and the defendant physician a non-judicial hearing before three of his peers.

The Act covers private health care providers, licensed in Louisiana, who are "qualified" with the Patients' Compensation Fund (PCF). To be "qualified," a health care provider must maintain primary coverage of $100,000 through an insurer such as LAMMICO, OR self insure by posting $125,000 security bond with the PCF, and pay a surcharge to the PCF.

The Act was passed in response to a crisis in the malpractice industry and covers alleged acts of malpractice occurring after 9/1/75. There have been many amendments to the statute since that time. Most recently, on September 27, 2006 the 3rd Circuit Court of Appeal in Lake Charles ruled that the Medical Malpractice Act's $500,000 cap on damages was unconstitutional because it violated the Louisiana Constitution's guarantee of an Adequate Remedy. The case went before the Louisiana Supreme Court and on February 2, 2007, the Louisiana Supreme Court announced that it had accepted the writs in the Arrington and Taylor cases. It ruled that the 3rd Circuit's judgments were vacated and set aside in those two cases. The Court held that the issue of adequate remedy was never properly before the courts, and therefore could not be legally ruled upon by the 3rd Circuit. The Supreme Court also remanded the cases back to the

3rd Circuit.

On July 6, 2007, the Third Circuit vacated the old ruling of the trial court that the medical malpractice cap was constitutional and remanded the case back to the trial court for a contradictory hearing on all issues to allow the plaintiffs to particularize all grounds for their claim that the cap is unconstitutional in a proper amending and supplemental pleading and to afford the State, the Patient Compensation Fund Oversight Board, and all parties in interest an opportunity to fully address and litigate the grounds alleged.

Although the ultimate outcome is uncertain, it may be a year or two before this is resolved.

For information about LAMMICO's proactive approach to the cap challenges, read the letter from Chairman/CEO John Lemoine in the March/April, 2007 issue of *the Letter*. Updates to the cap challenge cases can be found in future issues of the Letter, or by visiting our Web site. Should you have concerns about whether the limits you purchased on your medical malpractice coverage adequately cover your practice, contact LAMMICO's Underwriting Department at (504) 831-3756 or (800) 452-2120.

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How does the Medical Malpractice Act benefit Louisiana practitioners?

The cap tempers the severity of claims. Most judgments/settlements are capped at $500,000, which means that when a claim falls within the Medical Malpractice Act, physicians are not faced with multi-million dollar awards.

Also, insurance companies are better able to predict the judgment/settlement component of premiums. This helps stabilize premiums, thus reducing wild fluctuations in rates.

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Are there disadvantages of the Louisiana Act?

Yes. The medical review panel process, while affording the defendant physician a hearing before his peers, also allows plaintiffs to make claims much more easily, thereby increasing the number of non-meritorious claims. This, in turn, increases the frequency component of rates.

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Is the federal government doing anything about the med mal crisis?

At the federal level, medical liability tort reform is an important issue. In 2003 and 2004, the U.S. House of Representatives passed tort reform measures. However, these measures did not become law as they were defeated in the U.S. Senate.

On July 25, 2002, President Bush spoke out against what he called the "broken liability system." Bush said, "too many lawsuits filed against American doctors...have no merit." The speech followed a report released by the Department of Health and Human Services titled, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System." The report provides a review of the current medical malpractice market and predicts dire consequences for all Americans if action is not taken at the federal level. HHS pinpoints the litigation "lottery" as the source of the crisis, makes several recommendations for reforming the litigation system, and insists that real change can occur only through federally enacted reforms. View a full copy of the report from the White House's Web site.

On January 16, 2003, President Bush made his most forceful speech yet on the medical malpractice crisis. Placing the blame for the current crisis squarely with the excessive number of non-meritorious claims, Bush detailed his plan for a $250,000 cap on non-economic damages.

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What is the Louisiana government doing about the med mal crisis?

LAMMICO has worked with the state legislature to promote physician-friendly legislation. Changes to the Medical Malpractice Act in 2003 require that plaintiffs pay a filing fee and make brief allegations against each named defendant when requesting a medical review panel. This fee offsets some of the administrative costs to the Patients' Compensation Fund in processing an increasing number of claims, and decreases the number of non-meritorious claims filed against health care providers. These changes passed thanks to Senator Dr. Donald Hines and Representative Ronnie Johns. LAMMICO sponsored the introduction to the bill and worked with the LSMS to ensure that changes to the MRP make it a better and more efficient process.

In 2004, a significant change that LAMMICO pursued was Senate Bill 302, which makes the filing of a request for a medical review panel (MRP) "not reportable by any health care provider to the Louisiana State Board of Medical Examiners, to any licensing authority, committee, or board of any state, to any credentialing or similar agency, committee, or board of any clinic, hospital, health insurer, or managed care company." This is a real victory for health care providers in Louisiana, who face a high number of non-meritorious filings, and thus may be viewed by national credentialing agencies as having an excessive number of claims.

Most recently, LAMMICO was instrumental in passing the Abridged MRP Act. The law, introduced by Senator Arthur J. Lentini, and supported by LAMMICO, calls for an expedited medical review panel (MRP) for medical malpractice claims. The law was effective August 15, 2006. The goal of this legislation is to shorten the time to conclusion of a medical malpractice claim, and to reduce the cost of moving claims through the legal process. All parties must agree to this "abridged" option, which creates another tool to enable a quality, cost-effective defense. The defense team, comprised of the defense attorney, claims representative and the physician, will evaluate whether or not the abridged MRP should be selected, based on a defense strategy that is tailored to each claim.

LAMMICO is committed to continuing our work in the state legislature. Through cap challenges, medical review panel modifications, and whatever else Louisiana health care providers may face, LAMMICO will be there to fight for you, not only as your insurance company, but as your advocate. To learn more about Louisiana Legislature and LAMMICO's involvement, visit our Physician Advocacy section.

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What is frequency?

Frequency refers to the number of claims filed per physician. High frequency means that more than the average number of claims are being filed.

Frequency is the single biggest problem in Louisiana. That means that the number of claims is higher than the national average. Thanks to recent legislative changes promoted by LAMMICO, the frequency rate does seem to be decreasing. For more information on our legislative activities, view our Physician Advocacy Timeline.

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What is severity?

Severity is the judgment/settlement component of the cost of a claim. High severity indicates that the judgments/settlements are large.

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Why are premiums so high?

In 2007, LAMMICO was pleased to have for the third year in a row a 0% overall rate increase. The most important factors in determining rates are frequency and severity. Severity—the cost and size of a judgment/settlement—is not a significant problem in Louisiana because of the cap. We do not see million-dollar plus verdicts in Louisiana like those which occur in states without caps.

The single biggest problem in Louisiana is frequency. That means that the number of claims is higher than the national average. Thanks to recent legislative changes promoted by LAMMICO, the frequency rate does seem to be decreasing. For more information on our legislative activities, visit our Physician Advocacy section.

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What can I do to lower my premiums?

The minimum underlying limit required to qualify under the medical malpractice cap is $100,000 per incident / $300,000 aggregate. The majority of LAMMICO policyholders choose higher limits of coverage. We do not advise decreasing limits as a way to lower your premiums. Chose your limits based upon the potential exposure you have. Lowering your limits might be a good idea if you have changed certain aspects of your practice.

Because LAMMICO understands the cost associated with your medical professional liability coverage, we offer several discounts to help make your premium more affordable. We offer the following discounts to qualifying physicians:

Risk Management Credit: A 10 percent credit to the basic limits portion of your premium for successfully completing two risk management programs either online or by attending a live lecture. We ask you to complete the programs at least 60 days prior to your renewal month to allow time for processing.

New-to-Practice: A 50 percent credit to your LAMMICO premium for your first 12 months of practice.

Part-time: If you practice 85 hours or less a month, you may receive a percentage off both your LAMMICO premium and PCF surcharge.

Temporary Disability or Sabbatical: Credit for up to six months.

Deductibles: You may receive a credit for retaining a portion of each claim.

Good Experience Credit: In direct response to our policyholders' concerns, in 2005 LAMMICO introduced a "Good Experience Credit" of 10 percent for long-term policyholders with excellent loss experience. Premium renewal letters will indicate whether a physician meets the criteria for this discount. If eligible, physicians will be able to earn both the

good experience credit and risk management discount. On July 1, 2007, LAMMICO expanded its Good Experience Discount Program. Now, more physicians will become eligible to receive the discount. We have reduced the eligibility period from seven years insured to five. The discount has benefitted more than 1,400 physicians and we look forward to more of you joining them.

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How are professional liability rates calculated?

Calculating your medical professional liability insurance premium involves many factors. As a policyholder-owned company, LAMMICO is committed to providing you with the lowest possible rates consistent with sound underwriting principles.

Specialty
LAMMICO insures health care practitioners in most medical and dental specialties and subspecialties. For each specialty, LAMMICO's actuary designates a premium rate classification. Currently, there are rate class designations ranging from Class 1A (lowest) through Class 8 (highest). Liability risk factor statistics, such as claim frequency and severity trends – known as loss experience – determine a given specialty's classification.

Limits of Liability
LAMMICO offers two types of policy options:

- **Basic limits** provide you with up to $100,000 per incident per year, and up to $300,000 for the year, for covered capped losses (and covered losses that are uncapped due to failing to qualify under the Act). Plus LAMMICO provides you with $100,000 per incident per year, and up to $300,000 total for the year for covered uncapped claims (other than those where you are uncapped due to failing to qualify under the Act.)

- **Higher limits** provide you with additional coverage in the event of an uncapped claim (other than one that is uncapped due to failing to qualify).

Rate Adjustments
Your mature-rate premium will remain stable, changing only when general rate adjustments become necessary. As with all types of insurance, medical professional liability rates reflect the amount of estimated risk based on your personal claims experience, as well as the claims experience of your specialty. The two main variables that determine these premiums are the frequency and cost of claims for each specialty.

Because LAMMICO wants to provide you with the lowest possible rates, we conduct an annual actuarial review to set rates and designate rate classifications. Annual reviews and rate adjustments help LAMMICO keep premiums at the lowest possible level that will still ensure that LAMMICO will be here for you in the long-run.

Geographic Territorial Rating
The practice location plays a role in the level of risk and premium paid. LAMMICO has four rating territories – New Orleans metropolitan area (Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, and St. John the Baptist Parishes); Calcasieu Parish; Caddo and Bossier Parish; and the remainder of the state. Depending on which rating territory you practice in, the claims experience of that area will also be a factor in your rates.

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What limit options does LAMMICO offer?

LAMMICO offers two types of policy options:

Basic limits provide you with up to $100,000 per incident per year, and up to $300,000 for the year, for covered capped losses (and covered losses that are uncapped due to failing to qualify under the Act). Plus LAMMICO provides you with $100,000 per incident per year, and up to $300,000 total for the year for covered uncapped claims (other than those where you are uncapped due to failing to qualify under the Act.)

Higher limits provide you with additional coverage in the event of an uncapped claim (other than one that is uncapped due to failing to qualify). Because many health care providers are concerned about the potential liability involved with uncapped claims, they are choosing higher coverage limits. This coverage provides peace of mind to LAMMICO policyholders because they are more comfortable knowing they have increased limits.
If you have additional questions, visit our Frequently Asked Questions section or contact our Underwriting Department at (504) 831-3756 or (800) 452-2120.

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HEALTH INSURANCE & RETIREMENT INFO

FELLOWS AND HOUSE OFFICERS

EMPLOYER SPONSORED HEALTH INSURANCE

WHEN COVERAGE ENDS

Coverage is in effect through the last day of the month in which you are employed. For example if your last day of employment is June 2nd, then coverage runs through June 30th. If your last day of employment is June 30th, coverage ends the same day.

COBRA

An extension of coverage is available under COBRA for a maximum of 18 months. You are continuing the exact same coverage as you had as an active employee so there is no difference in what the plan will cover or how it will be covered.

Premiums will rise significantly as you will now be responsible for the full cost of the plan plus a 2% administration fee. As an active employee, your employer paid 75% of the premium cost and you paid 25%. The GB01 to request a COBRA packet is available on the LSUHSC Human Resources Management web site (see link below) or from the Benefits Office. You will have a 60 day window to elect the continuation of coverage. For those electing coverage, the effective date is retroactive to the termination date providing continuous coverage.

Please understand that COBRA is a retroactive enrollment. It is virtually impossible to have a COBRA policy in place for a seamless transition from active coverage. Federal law requires payment of any claims incurred during the 60 day election period once COBRA is in place. No provider will activate COBRA coverage without payment in advance for premiums owed or while they can see active coverage in the system.

The Office of Group Benefits administers COBRA for the PPO, EPO United HealthCare and Humana health plans. Ceridian Benefits is the COBRA administrator for the LSU First health plan, Options 1 and 2. The COBRA administrator issues continuation of coverage packets, collects premiums and activates coverage.

PORTABILITY

For those of you who will obtain new health coverage, federal law allows a break in coverage of up to 62 days in applying previous health coverage to reduce or eliminate pre-existing condition exclusions of a new group plan. Private health insurance companies are not required by federal law to credit you for previous coverage and are free to impose pre-existing coverage restrictions.

TRANSFER TO ANOTHER STATE AGENCY

If you are accepting employment with another state agency, please contact the Benefits Office so we can work with the receiving agency to ensure a smooth transfer of coverage.

SPOUSAL TRANSFER

If your spouse works for us or another state agency in a benefits eligible position, there are special procedures in place to allow a transfer of coverage. **Contact the Benefits Office prior to termination of employment so we can help you with the process. If you wait until coverage with us has terminated, it may be too late to avoid a break in coverage.**

STUDENT HEALTH INSURANCE

Student health insurance is not eligible for continuation of coverage through COBRA. The LSUHSC Benefits Office does not handle student insurance. Contact Michele Prudhomme with Gallagher Benefits at 225 906-1278 or 800 605-6102 for assistance with the student health plan.

DENTAL, VISION PLANS

Ameritas, the Dental provider and Starmount, the vision plan provider will provide COBRA packets to allow continuation of those benefits for a maximum of 18 months. You already pay the full cost of these plans, however the COBRA administrator is allowed to impose a 2% administration fee.

HEALTH CARE/CHILD CARE FLEXIBLE SPENDING ACCOUNTS

You are not eligible to be reimbursed for expensed incurred **AFTER** your termination date. You have 120 days from your termination date to submit eligible claims for reimbursement.

Although it may be possible to COBRA participation through the end of the plan year, you will loose the benefit of making pre-tax contributions.

LSU SYSTEM LIFE INSURANCE/OFFICE OF GROUP BENEFITS LIFE INSURANCE

If you wish to convert your group life insurance plan to a private policy, please contact the Benefits Office for the necessary paperwork. Conversion packets are issued only upon request.

DEFERRED COMPENSATION (GREAT WEST)

Members may leave their contributions with the Deferred Compensation Plan upon termination or request a rollover or cash payout of their contributions to the plan.

Cash withdrawals are taxable income to you, but are not subject to the 10% penalty.

For rollovers/payouts, members need to contact Great West at 800 345-4699 or visit their web site at www.LouisianaDCP.com.

Members who leave the US are advised to request a wire transfer of their funds rather than requesting a check easily lost when mailed internationally.

403(b) VOLUNTARY RETIREMENT PLANS

Members may leave their contributions with the plan upon termination or request a rollover or cash payout of their contributions. Contact the vendor to obtain the necessary rollover/payout forms

Contributions that are rolled into another qualified retirement plan or IRA are exempt from taxation or penalties. Members age 59 ½ or individuals who are disabled may withdraw funds without 10% penalty the IRS normally imposes.

The Benefits or Payroll Office has designated staff authorized to sign off as the plan administrator when requesting a withdrawal.

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS and
HEALTH MAINTENANCE ORGANIZATION/HMO
ENROLLMENT/CHANGE FORM

Agency Number	Agency Name	Date of Hire	Annual Salary	Employee Name changed to:

A. PURPOSE

☐Waiver of Coverage ☐Agency Transfer (Receiving Agency) ☐New Enrollment ☐Reinstate Coverage ☐Re-enrollment–Previous Employment ☐Annual Enrollment
☐Add/Delete Dependent(s) _____ Reason for Addition/Deletion _____
Date

☐Surviving Spouse/Dependent ☐Special Enrollment ☐Late Applicant – Portability Law Applies? ☐No ☐Yes Retired _____
Date

☐Employment Terminated _____ ☐For gross misconduct ☐Deceased _____
Date Date

☐Cancel all coverage _____
Reason for Cancellation

☐Primary Care Physician Change ☐Name/Address Change ☐Other

B. PERSONAL INFORMATION – EMPLOYEE (Please print or type)

Last Name, First, MI					
Name		Social Security Number	Date of Birth		
Address		City	State	Zip Code	
Home Phone	Work Phone	Extension	Sex ☐Male ☐Female	Marital Status 1.☐Single 2.☐Married	Date of Marriage / Date of Divorce

C. HEALTH PLAN SELECTED:

D. LEVEL OF MEDICAL COVERAGE SELECTED ☐ No Coverage ☐ Employee Only ☐ Employee + Child/Children ☐ Employee + Spouse ☐ Family

Name (Last Name, First, MI)	Relation - ship	Sex	Birth Date (mm/dd/ccyy)	Add/Delete	Social Security Number	Health	Dep Life	HMO Requirement: Primary Care Physician Name	HMO Requirement: Previous Patient	HMO Use Only: Physician #
Employee		☐ M ☐ F		☐ Add ☐ Delete					☐ No ☐ Yes	
Spouse		☐ M ☐ F		☐ Add ☐ Delete		☐Yes	☐Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐Yes	☐Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐Yes	☐Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐Yes	☐Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐Yes	☐Yes		☐ No ☐ Yes	

Are you or family members listed above covered by any other group health insurance/HMO from another employer/organization/Medicaid? ☐No ☐Yes. If Yes provide the following:

Policy Holder's Name	Social Security Number	Birth Date	Policy Number	Group Number	Coverage Type	Effect Date

Employer/Company	Insurance Company/HMO (Name/Address/Phone)	Persons covered under other policy

E. COBRA

☐ Prior P/T Terminated ☐ Prior F/T Terminated ☐ Prior F/T – Part Time ☐ Divorced Spouse ☐ Continued Dependent

Name of original member _____ Social Security Number _____

F. MEDICARE

Employee	Spouse
☐ 1. No Coverage ☐ 2. Hospital (Part A) ☐ 3. Medical (Part B) ☐ 4. Hospital &Medical	☐ 1. No Coverage ☐ 2. Hospital (Part A) ☐ 3. Medical (Part B) ☐ 4. Hospital &Medical

A COPY OF MEDICARE CARD MUST BE ATTACHED

G. RETIREE 100

☐ Yes ☐ No

☐ Employee Only
☐ Dependent Only
☐ Employee & 1 Dependent

H. MENTAL HEALTH RIDER

☐ Yes ☐ No

I. WAIVER OF COVERAGE

I waive all coverage under the Office of Group Benefits/HMO and I understand if I enroll at a future date that the coverage will be subject to the evidence of insurability for life insurance and a Pre-Existing Condition (PEC) for health insurance, and may be conditional.

NOTE TO AGENCY REPRESENTATIVE: If employee waives right to all coverage, he/she must sign an enrollment document. A copy of this document is to be retained by the Agency as evidence the Employee was offered coverage within 30 days of eligibility and the employee declined. The original of this document is to be transmitted to Group Benefits.

EMPLOYEE SIGNATURE _____ DATE _____

J. LIFE INSURANCE (Check only one)

☐ No Coverage Employee/Dependent

BASIC

☐ Employee/No Dependent Coverage
☐ Employee/dependent Coverage
Eligible Spouse $1,000 Eligible Child $500
☐ Employee/Dependent Coverage
Eligible Spouse $2,000 Eligible Child $1,000

BASIC PLUS SUPPLEMENTAL

☐ Employee/No Dependent
☐ Employee/Dependent Coverage
Eligible Spouse $2,000 Eligible Child $1,000
☐ Employee/Dependent Coverage
Eligible Spouse $4,000 Eligible Child $2,000

NOTICE: YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

I reviewed the descriptive literature about the Plans available to me. I apply for participation/change in the named health plan and agree to be bound by its terms and conditions. I authorized deductions from my earnings or retirement check to pay for insurance for myself and dependents, if applicable. I CONSENT TO THE MEDICAL RELEASE AND OTHER ENROLLMENT INFORMATION ON THE BACK OF THIS FORM. I certify that the information provided on this form is true and correct. I understand that if I provide material false information on this form, it may result in denial or recision of coverage retroactive to the initial day of coverage. A copy of my signature is as valid as the original.

Employee Signature _____ Date _____

Agency Rep. _____ Date _____

Annual Salary _____

Date of Last Salary Increase _____ Face Life _____

OFFICE USE ONLY

Life _____ Health _____ E of I _____ Specialist Int. _____ Date _____

WHITE - GROUP BENEFITS CANARY – HMO PINK – AGENCY GOLDENROD – PLAN MEMEER

Medical Release

I authorize health care providers of services to me and my dependents to release information (including information related to diagnosis or treatment of mental health and/or substance abuse problems, or acquired immune deficiency syndrome) to my HMO or Office of Group Benefits and all participating providers to the extent necessary to determine responsibility for payment of claims and for utilization review and quality assurance purposes. A copy of this authorization is as valid as the original.

I understand that the names of participating providers in my HMO or PPO (health plan) may change during the plan year. The health plan does not guarantee the continuing participation of the named health care providers.

Plan Members With Enrolled Children Please Note:

IF YOU ARE DIVORCED AND HAVE CHILDREN UNDER AGE 18 AND IF A COURT ORDER HAS BEEN ISSUED ASSIGNING FINANCIAL RESPONSIBILITY, YOUR HEALTH PLAN MUST BE PROVIDED WITH A COPY.

IF THE CHILD IS OVER AGE 21, PROOF OF FULL TIME STUDENT STATUS FROM AN ACCREDITED SCHOOL MUST BE PROVIDED TO YOUR HEALTH PLAN AT THE TIME OF INITIAL ENROLLMENT AND AT THE START OF EACH SEMESTER.

New Hires and Acknowledgements

I acknowledge that my application will be approved on a conditional basis.

I understand that unless the Portability Law applies, 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.

I understand that any disease, illness, accident, or injury will be classified as a pre-existing condition if, during the six-month period preceding the effective date of coverage, any treatment or services were received or drugs were prescribed for such disease, illness, accident, or injury.

The term Treatment shall mean all steps taken to effect the cure of a disease, illness, accident, or injury and shall include, but not be limited to, consultations, examinations, diagnosis, and any application of remedies.

I accept the conditional approval for coverage and agree that this declaration will become a part of my application for coverage.