

# HIPAA PLAN

## Louisiana Health Plan

### INSTRUCTIONS FOR COMPLETION OF APPLICATION

1. A separate application must be completed for each person who is applying for coverage. Individual policies will be issued to each person enrolled. There is no group coverage available.
2. Please select the annual deductible you would like for the calendar year, Plan J, K, L or M. Plan J is \$1,000 deductible; Plan K is \$2,000 deductible; Plan L is \$3,500 deductible; and, Plan M is \$5,000 deductible. You must meet the annual deductible you select for each calendar year. At the close of every year, each policyholder will be sent a renewal form along with the rates for the following year. The premium rates are adjusted annually. The policyholder has the opportunity to select his deductible for the following year. The deductible can only be changed at the time of renewal.
3. The premium rates are listed on the attached rate table (gray sheet).
  - a. Locate your geographic location using the “Zip Code Guide”. For example, if you live in the zip code 70816, your rates will be in the section labeled “Baton Rouge & Shreveport”.
  - b. If you are a **smoker**, use the “**Standard Rates**” (left side of page).  
  
If you have **not smoked cigarettes, cigars, pipe, or utilized other tobacco products in the last year, you will use the “Discounted Rate”** (right side of page).
  - c. Use the appropriate male/female category.
  - d. Use the correct age category.
  - e. Select the deductible that you would like.
4. **Read the application information and questions carefully and answer them honestly and completely. Any false statements can result in loss of coverage.**
5. You must enclose a check for one month’s premium with your application. Make sure that your **check is made payable to “LHP – Louisiana Health Plan”** and be sure that it is dated and signed. Checks will not be considered as “paid” until cleared. **Your policy will NOT be effective until the first month’s premium is paid-in-full.**
6. Please be sure to enclose a photocopy of your driver’s license or a utility receipt for proof of your Louisiana residency.
7. You must return your application by U. S. Mail or express delivery service. We strongly suggest that you **send the application via Certified Mail, Return Receipt Requested if you are utilizing U.S. Mail.**
8. If you have any questions or need assistance regarding this application, you may contact the LHP office or your local health insurance agent. The LHP toll-free office number is 1-800-736-0947, or in Baton Rouge the number is 926-6245.

**LOUISIANA HEALTH PLAN**

**P. O. Drawer 83880**

**Baton Rouge, LA 70884-3880**

**(225) 926-6245 1-800-736-0947**

# LOUISIANA HEALTH PLAN

P. O. Drawer 83880

Baton Rouge, Louisiana 70884-3880

(225) 926-6245 Fax (225) 927-3873

## PREMIUM PAYMENTS

1. **Premium payments can ONLY be made by personal check.** All payments must be by **personal check** drawn on the account of the policyholder. *No business or other “third party” checks OF ANY KIND will be accepted.* The only exceptions to this policy are:
  - LHP will accept the **personal check** drawn on the account of **the policyholder’s parent or legal guardian.**
  - LHP will accept the check drawn on a **trust account** established **individually** for the policyholder (no group, government or class trusts).
  - LHP will accept **money orders or certified funds** *only after the policyholder has contacted LHP and signed a statement attesting to the source of the funds.* To obtain an affidavit, contact Diane Brunecke at 1-800-736-0947, Extension 103 or in Baton Rouge 926-6245, Extension 103. E-mail: [dbrunecke@lahealthplan.org](mailto:dbrunecke@lahealthplan.org)
  - **No cash** is ever accepted.
2. **Premium payments will be deposited immediately upon receipt.** We will not “hold” checks. Please make sure that your account has sufficient funds for payment. All NSF checks will be posted as “non-payment” of premium.

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**P. O. Drawer 83880**  
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**INCOME QUESTIONNAIRE**

Please complete the following questionnaire. We ask for this information in the event there is additional funding available based on member income. Your answer will not affect your premium or eligibility. *Please note that no exact dollar figure is required at this time.*

If your family income is equal to, or less than, the figures in the chart, Louisiana Health Plan may contact you. Further information may be required.

I, \_\_\_\_\_, have reviewed the family income schedule below.  
 (please print your name)

<u>Number in Family</u>	<u>Gross Weekly Income *</u>	<u>Gross Monthly Income *</u>
1	\$386	\$1,670
2	\$519	\$2,246
3	\$652	\$2,823
4	\$785	\$3,399
5	\$918	\$3,976
6	\$1,051	\$4,553
7	\$1,184	\$5,129
8	\$1,317	\$5,706
More than 8	For each extra person, add \$134 to the weekly amount for 8 people	For each extra person, add \$577 to the monthly amount for 8 people

*\* Income amounts reflect 185% of 2010 Health and Human Services Guidelines. Gross Income is your income without any deductions.*

My family income:

- is EQUAL to, or LESS than, the schedule above
- is GREATER than the schedule above

Please check all that apply:

- I have a spouse
- I have a child aged 18 or younger living in my house. If yes, how many children ages 18 or younger live in your house? \_\_\_\_\_
- I have a disabled dependent child older than 18 years living with me

\_\_\_\_\_  
 Signature of Policyholder

\_\_\_\_\_  
 Date

Or Signature of Parent or Legal Guardian if the Policyholder is Under 18 years of age, interdicted or a full-time student at an out-of-State tuition at the non-Louisiana educational facility

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## DEDUCTIBLE PROCEDURE

**Before you select your deductible for the year, please note that at renewal time in December each year (and for the lifetime of your policy) you will ONLY BE ALLOWED TO SELECT THE SAME OR HIGHER DEDUCTIBLE.** Therefore, if you select a \$2,000 deductible this year, you will only be allowed to remain at the \$2,000 deductible or select a \$3,500 or \$5,000 in the future. If you select a \$5,000 deductible, you will not be allowed to change to a lower deductible.

The Out-of-Pocket Maximums are:

Deductible Amount	Maximum out-of-pocket Expense for each Covered Person INCLUDING THE DEDUCTIBLE	
\$1,000	\$4,500	(\$1,000 Deductible + \$3,500)
\$2,000	\$6,500	(\$2,000 Deductible + \$4,500)
\$3,500	\$8,000	(\$3,500 Deductible + \$4,500)
\$5,000	\$9,500	(\$5,000 Deductible + \$4,500)

**Please sign, date and return:**

Yes, I have read the statement above and understand that at the annual renewal of the policy, I will only be able to select the same or higher deductible.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



**PART II.**

**ELIGIBILITY REQUIREMENTS**

**Question 1.** Are you a resident of the State of Louisiana?

Answer Yes \_\_\_\_\_

No \_\_\_\_\_

If yes, **please attach at least one of the following documents:** a copy of a current driver’s license, rent receipts, mortgage payment receipts, property tax receipts, utility bills, or other proof of residency.

**Question 2.** Were you covered under “Creditable Coverage” for a total of at least 18 months before the date of this application without a “significant break in coverage”?

Answer Yes \_\_\_\_\_

No \_\_\_\_\_

If you responded “no”, you do not have to respond to the remaining questions.

Definitions to Assist in Responding to this Question

“Creditable Coverage” means any of the following types of coverage (including COBRA or continuation benefits available under any type of coverage listed):

Group Coverage

- A group health plan
- Group health insurance coverage (including an HMO)
- A church plan

Individual Coverage

- An individual health insurance policy
- A State health benefits risk pool

Government Plan

- A health plan offered under the Federal Employees Health Benefits Program
- A health plan offered by the State or any of its political subdivisions
- A health benefits plan under the Peace Corps Act
- Health coverage for uniformed services (including the Commissioned Corps of NOAA and PHS)

Public Benefits

- Medicare
- Medicaid
- A medical care program of the Indian Health Service or of a tribal organization

A “significant break in coverage” means that the applicant has a period of 63 consecutive days during which the applicant had no health coverage. Any applicable waiting periods or affiliation periods are not counted against the 63-day period.

**Question 3.** Please indicate below whether or not your most recent "Creditable Coverage" was under one of the following

Group Coverage \_\_\_\_\_ Date Ended \_\_\_\_\_

Government Plan \_\_\_\_\_ Date Ended \_\_\_\_\_

Individual Coverage \_\_\_\_\_ Date Ended \_\_\_\_\_

If your last creditable coverage was individual coverage, please state whether the coverage was terminated because the carrier discontinued that product in the state of Louisiana or discontinued all individual coverage in the state of Louisiana

Yes \_\_\_\_\_ No \_\_\_\_\_

If your last carrier offered you an alternative policy or plan, please attach a copy of such offer to this application.

Are you eligible for Veteran's Benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

**You must provide proof of the "Creditable Coverage" before a policy can be issued.** If you currently have your Certificate, please enclose it with this application. Many carriers will not issue this Certificate until AFTER your COBRA has been exhausted. Therefore, you can submit your Certificate AFTER you submit this application.

**Question 4.** Please state whether or not such coverage was terminated because of non-payment of premium, fraud, or because of an intentional misrepresentation of material fact in connection with such coverage.

Answer Yes \_\_\_\_\_

No \_\_\_\_\_

**Question 5.** Please state whether or not COBRA or continuation benefits were offered to you.

Answer Yes \_\_\_\_\_

No \_\_\_\_\_

**If not,** please have your previous employer (or the employer's health plan) write a letter explaining why you were not offered COBRA or continuation benefits and mail it to:

**Attn: HIPAA  
Louisiana Health Plan  
P. O. Box 83880  
Baton Rouge, LA 70884**

**Questions 6.** If currently on COBRA or continuation benefits, please state the date upon which your COBRA or continuation benefits will terminate \_\_\_\_\_

If your COBRA or continuation benefits have already been exhausted, please state the last day upon which you had COBRA or continuation benefits \_\_\_\_\_

**Question 7.** Are you currently eligible, either individually, as a spouse, or as a dependent child, for major medical insurance under a group health plan, Medicare or Medicaid?

Answer Yes \_\_\_\_\_

No \_\_\_\_\_

If major medical coverage under a group health plan, please list the name, address and telephone number of the insurance company, the policy number and the effective date

If Medicare, please list the effective date \_\_\_\_\_

If Medicaid, please list the effective date \_\_\_\_\_

**Question 8.** Have you filed for Medicare or Medicaid benefits?

Answer Yes \_\_\_\_\_

No \_\_\_\_\_

If yes, state the date of filing and application or processing number. \_\_\_\_\_

**Question 9.** Are you, either individually, as a spouse, or as a dependent child, covered by major medical health insurance (including any individual policy)?

Answer Yes \_\_\_\_\_

No \_\_\_\_\_

If yes, please state the name, address and telephone number of the insurance company, the policy number and the effective date.

**Question 10.** Are you or your spouse employed? If you are a dependent child, are either of your parents or legal guardians employed?

Answer Yes \_\_\_\_\_

No \_\_\_\_\_

If yes, please state the name, address and telephone number of the employer(s).

**Question 11.** If you or your spouse are employed, does the employer offer major medical insurance coverage? If you are a dependent child, and either of your parents or legal guardians are employed, does the employer offer major medical insurance coverage?

Answer Yes \_\_\_\_\_

No \_\_\_\_\_

If yes, please state the policy and group number, the name of the insured, whether or not you are eligible for the insurance coverage, and if not, why not.

**Question 12.** Are you an inmate of a public institution?

Answer Yes \_\_\_\_\_

No \_\_\_\_\_

**Question 13.** Have you applied for, or are you currently insured by a high risk health insurance pool (HIPAA Plan) in another state?

Answer Yes \_\_\_\_\_

No \_\_\_\_\_

If yes, please provide the following:

Name of Applicant:

Name of Company/Risk Pool:

Address:

Telephone Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Question 14.** Have you ever smoked cigarettes, cigars, pipe or used tobacco products of any kind?

Answer Yes \_\_\_\_\_

No \_\_\_\_\_

If yes, have you quit? Yes \_\_\_\_\_ No \_\_\_\_\_

If you have quit, for how long? \_\_\_\_\_ years \_\_\_\_\_ months

**PART III. PREMIUM** (Refer to the Premium Rate Table)

Please make sure that you have the correct Plan and that you have utilized the appropriate age, sex, geographic region and Standard/Discounted status. Please note that moving to a different geographic location band or having a birthday that places the applicant/policyholder in a different age bracket will change the premium payable.

A. Initial premium enclosed in the amount of \$\_\_\_\_\_. Please **make check payable to Louisiana Health Plan.**

**PART IV. RELEASE OF INFORMATION AND AUTHORIZATION**

I authorize any employer, insurance company, organization, or provider of services to release any information related to my eligibility determination or any medical condition which I may have and for future claims submitted to the Louisiana Health Plan for payment.

\_\_\_\_\_  
Signature of Application or Signature of Parent or Legal Guardian  
(if the applicant is under age 18 or interdicted) \_\_\_\_\_  
Date

**PART V. GENERAL AGENT OR BROKER CERTIFICATION** (If applicable)

If a broker or general agent is assisting with the application: I certify that I have gone over LA R.S. 22:250.12 (B) with the applicant, including eligibility requirements, benefits, premiums, policy and informational materials. I have fully explained the options, benefits and provisions of the policy. I have assisted in the completion of this application in cooperation with the applicant. I am a duly licensed agent in good standing. I further certify that the applicant has signed his or her name in my presence or has verified to my satisfaction that it is the applicant's signature affixed to this application.

If a general agent or broker: I have explained to the applicant that I am not an authorized agent, broker, employee or representative of the Louisiana Health Plan and that I do not have the authority to issue or bind coverage on behalf of the Louisiana Health Plan.

Coverage will be issued by the Louisiana Health Plan and verified by the issuance of the policy and a certificate of coverage for any and all covered persons.

\_\_\_\_\_  
General Agent Signature \_\_\_\_\_  
License Number \_\_\_\_\_  
Month/Day Year

Please Print Name & Address: \_\_\_\_\_

\_\_\_\_\_  
Phone Number \_\_\_\_\_

\_\_\_\_\_  
Broker's Signature \_\_\_\_\_  
License Number \_\_\_\_\_  
Month/Day Year

Please Print Name and Address: \_\_\_\_\_

\_\_\_\_\_  
Phone Number: \_\_\_\_\_

**PART VI. MEDICAL QUESTIONS**

You must fill out all of these medical questions or your application will not be processed. (If you have any questions about filling out this information, please contact your doctor's office.)

No medical condition will preclude an applicant from obtaining coverage. All medical information provided by you will not be subject to any public records examination and will be held as confidential by Louisiana Health Plan.

**HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING**

	<b>YES</b>	<b>NO</b>
01. Asthma or other bronchial condition	_____	_____
02. Emphysema, tuberculosis or lung disorder	_____	_____
03. Cancer, Leukemia or Hodgkins disease (including malignant brain tumors)	_____	_____
04. Benign tumors, cysts and polyps	_____	_____
05. Colitis or intestinal disorder	_____	_____
06. Gall bladder disease or gall stones	_____	_____
07. Ulcers or other stomach or esophagus disorders	_____	_____
08. Chronic renal failure or polycystic-kidney disease	_____	_____
09. Other urinary system disorder (including other kidney disease/stones)	_____	_____
10. Stroke or paralysis	_____	_____
11. High blood pressure (indicate latest reading) _____/_____ (Systolic/Diastolic)	_____	_____
12. Third degree burns	_____	_____
13. Heart attack, heart disease or angina	_____	_____
14. Other disorders of the heart or circulatory system	_____	_____
15. Diabetes (indicate latest blood sugar level) _____/ (mg/dl)	_____	_____
16. Thyroid disorder or goiter	_____	_____
17. Chronic hepatitis	_____	_____
18. Other liver disorder (including cirrhosis)	_____	_____
19. Disorder of the spleen or pancreas	_____	_____
20. Seizure disorder	_____	_____
21. Multiple Sclerosis, Muscular dystrophy or other neuromuscular condition	_____	_____

\_\_\_\_\_ Date \_\_\_\_\_ Signature

## MEDICAL QUESTIONS CONTINUED

	YES	NO
22. Disorder of the brain or nervous system	_____	_____
23. Acute Leukemia	_____	_____
24. Other disorder of the blood/Anemia	_____	_____
25. Lupus	_____	_____
26. Disorders of spine, or discs	_____	_____
27. Disorders of joints or bones including arthritis	_____	_____
28. Disorders of the reproductive system	_____	_____
29. Sexually transmitted disease	_____	_____
30. Congenital (birth) diseases or defects	_____	_____
31. AIDS, AIDS-Related Complex, or Disorder of Immune System (including HIV Positive results)	_____	_____
32. Other _____	_____	_____
33. Are you taking prescription drugs to lower your cholesterol?	_____	_____
34. Mental or substance abuse, including depression, anxiety, bipolar disorder, addiction, or any other mental disorder or substance abuse diagnosis	_____	_____
35. What is your height (without shoes)? _____ ft. _____ in.		
36. What is your weight (without clothes)? _____ lbs		

\_\_\_\_\_ Date \_\_\_\_\_ Signature

### PART VII. PHYSICIAN INFORMATION

(1) **Please provide the names, addresses, and telephone numbers of all physicians who are presently treating you, or who have treated you in the last 5 years. Please sign and date any additional information which must be attached to this application.**

Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

(Street) (Area Code) (Number)

(City) (State) (Zip Code)

Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

(Street) (Area Code) (Number)

(City) (State) (Zip Code)

Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
(Street) (Area Code) (Number)

\_\_\_\_\_  
(City) (State) (Zip Code)

Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
(Street) (Area Code) (Number)

\_\_\_\_\_  
(City) (State) (Zip Code)

**PART VIII. PRESCRIPTION INFORMATION**

(1) Have you taken prescribed medications within the last year? \_\_\_\_Yes \_\_\_\_No

(2) If yes, please complete the following: Please sign and date any additional information which must be attached to this application.

Name of Medicine \_\_\_\_\_

Dosage \_\_\_\_\_

Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_

Address and telephone of prescribing physician if NOT already provided:

\_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_

Dosage \_\_\_\_\_

Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_

Address and telephone of prescribing physician if NOT already provided:

\_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_

Dosage \_\_\_\_\_

Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_

Address and telephone of prescribing physician if NOT already provided:

\_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_

Dosage \_\_\_\_\_

Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_

Address and telephone of prescribing physician if NOT already provided:

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Name of Medicine \_\_\_\_\_

Dosage \_\_\_\_\_

Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_

Address and telephone of prescribing physician if NOT already provided:

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**PART IX CERTIFICATION OF INFORMATION**

I certify that the previous statements are true and accurate to the best of my knowledge, information and belief. I understand that no coverage will be made effective until all necessary documentation and the full initial premium is paid and THIS APPLICATION HAS BEEN APPROVED FOR ENROLLMENT. I further certify that if I change my residency from Louisiana to another location in Louisiana, I will promptly notify the Louisiana Health Plan of my new address. I UNDERSTAND THAT A FALSE STATEMENT OR MISREPRESENTATION ON THIS APPLICATION MAY RESULT IN LOSS OF COVERAGE. If I am signing as the Parent or Legal Guardian of a dependent child, I further certify that the dependent child who is applying for coverage is a resident of the state of Louisiana.

\_\_\_\_\_  
**Signature of Applicant or Signature of Parent or Legal Guardian  
(if the applicant is under age 18, or legally incompetent)**

\_\_\_\_\_  
**Date**

## MEDICAL QUESTIONS CONTINUED

For each question answered "YES" under "PART VI MEDICAL QUESTIONS", please answer the questions below. If you have answered "yes" to more than 4 questions, please make additional copies of this sheet before proceeding.

1. Question Number	# _____	# _____
2. When did this condition first occur?	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____
3a. Is ongoing treatment for this condition being provided?	Yes _____ No _____	Yes _____ No _____
3b. If not, when did the last treatment occur?	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____
3c. If not, has treatment been recommended for this condition?	Yes _____ No _____	Yes _____ No _____
4a. Did the condition result in hospitalization?	Yes _____ No _____	Yes _____ No _____
4b. If yes, when did this occur?	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____
4c. If yes, duration of hospital stay?	Less than 5 days _____ 5-10 days _____ More than 10 days _____	Less than 5 days _____ 5-10 days _____ More than 10 days _____
4d. If yes, was surgery performed?	Yes _____ No _____	Yes _____ No _____

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

## MEDICAL QUESTIONS CONTINUED

For each question answered "YES" under "PART VI MEDICAL QUESTIONS", please answer the questions below. If you have answered "yes" to more than 4 questions, please make additional copies of this sheet before proceeding.

1. Question Number	# _____	# _____
2. When did this condition first occur?	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____
3a. Is ongoing treatment for this condition being provided?	Yes _____ No _____	Yes _____ No _____
3b. If not, when did the last treatment occur?	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____
3c. If not, has treatment been recommended for this condition?	Yes _____ No _____	Yes _____ No _____
4a. Did the condition result in hospitalization?	Yes _____ No _____	Yes _____ No _____
4b. If yes, when did this occur?	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____
4c. If yes, duration of hospital stay?	Less than 5 days _____ 5-10 days _____ More than 10 days _____	Less than 5 days _____ 5-10 days _____ More than 10 days _____
4d. If yes, was surgery performed?	Yes _____ No _____	Yes _____ No _____

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

# **Louisiana Health Plan**

**P. O. Drawer 83880**

**Baton Rouge, LA 70884-3880**

**(225) 926-6245 1-800-736-0947**

**FAX (225) 927-3873**

**Before mailing your application, please be sure that you have:**

- Signed each page of the application and medical questions where indicated**
- Enclosed a photocopy of the front and back of your drivers license or other proof of residency**
- Signed Deductible Procedure Form**
- Completed and Signed the Income Questionnaire**
- Enclosed a check in the exact amount for the first month's premium made payable to: "Louisiana Health Plan"**