State of Connecticut

INFERTILITY TREATMENT AND PROCEDURES DISCLOSURE FORM

Effective October 1, 2005, Public Act 05-196 requires any individual seeking individual health insurance coverage for infertility treatment and procedures to disclose to the individual's existing health insurance carrier any previous infertility treatment or procedures for which such individual received coverage under a different health insurance policy. For more information, please see Public Act 05-196 which can be accessed at the Connecticut General Assembly website at http://www.cga.ct.gov/2005/act/Pa/2005PA-00196-R00SB-00508-PA.htm

COMPLETE THIS FORM AND SEND IT TO YOUR CURRENT HEALTH INSURANCE CARRIER

Full Name of Individual Seeking Treatment_____
(first, middle, last)

Date of Birth:____/____/_____ Social Security Number_____/_____/_____

Covered as: [ ] Insured [ ] Dependent Name of Insured_____

Current Insurance Carrier _____Policy/ID #_____

[ ] Individual Plan [ ] Group Plan Group Name (If applicable):_____

Insured Under this Policy Since: _____/_____/_____

Secondary Carrier Information (if applicable)

Name of Insurance Company:_____ Policy/ID#_____

Name of Insured: _____ Covered as: [ ] Insured [ ] Dependent

[ ] Individual Plan [ ] Group Plan Group Name _____

Group Number (If applicable): _____

Dates of Coverage: _____/_____/_____ through _____/_____/_____

Is this a fully insured or a self-insured plan (see below) [ ] fully-insured [ ]self-insured (MUST CONFIRM WITH YOUR EMPLOYER

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Prior Carrier Information

Name of Insurance Company:_____ Policy/ID#_____

Name of Insured: _____ Covered as: [ ] Insured [ ] Dependent

[ ] Individual Plan [ ] Group Plan Group Name _____

Group Number (If applicable): _____

Dates of Coverage: _____/_____/_____ through _____/_____/_____

Is this a fully insured or a self-insured plan (see below) [ ] fully-insured [ ]self-insured (MUST CONFIRM WITH YOUR EMPLOYER

Under a self-insured arrangement, the employer retains the responsibility to pay directly for health care services of the plan participants. Self-funded plans are subject to *federal law*, not state law. ***Services reimbursed under self-funded plans do not count toward the limits specified under this law.*** Services not reimbursed by any insurance carrier (paid out-of-pocket) also do not count toward the limits specified under this law. If you need additional space to record prior carrier information, please attach a separate sheet of paper.

I have reviewed the information submitted on these and the attached pages, and attest that the information is true and accurate. I hereby certify that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief. I acknowledge that I understand that a person who knowingly makes or causes to be made, or used, a false record or statement will be considered to commit insurance fraud for the purposes of receiving benefits to which the person is not entitled.

_____ _____

(Signature of Insured Individual Seeking Treatment) (Date)_____

Authorization to Release Medical Information

I, _____ hereby authorize the release of medical records necessary to verify previous infertility treatment and procedures. I understand that these records may be obtained from any and all previous health insurers and/or any relevant medical provider(s) and will be utilized solely for the purpose of determining previous infertility treatment and procedures applied towards the maximums identified in Connecticut Public Act 05-196.

_____ _____

Signature of Patient **Date_____**

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Previous infertility treatment or procedures covered by insurance (do not include treatment or procedures for which no insurance claim was made, submitted or paid). Services reimbursed under self-funded plans, or for which the person receiving treatment received no insurance benefits and paid cash do not count toward the limits specified under this law.

Treatment or Procedure (including drug therapy)	Number of Cycles	Dates Received	Name, Address, Phone of Provider Providing Treatment	Health Insurance Coverage Provided By

Other infertility treatment or procedures received: (please describe and provide dates and name of health insurer)

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