

INDIVIDUAL NOTICE OF PERIOD OF PRE-EXISTING CONDITION

This is a model Individual Notice of Period of Pre-Existing Condition Restriction, based on requirements reflected in regulations issued by the Departments of the Treasury, Labor and Health & Human Services. This Notice is provided if, after consideration of any applicable prior creditable coverage, a person still has all or some portion of the plan's pre-existing condition restriction left to satisfy.

This Notice should be provided as soon as reasonable practical after a prompt determination of the extent to which the pre-existing condition restriction applies. The Notice is NOT required if the person has no portion of the restriction left to satisfy.

To: *(Insert name of participant)*

Re: Application of Plan's Pre-Existing Condition Restriction to coverage of:

(Insert name of participant and/or any dependents who are subject to the pre-existing condition restriction after application of any creditable coverage)

The coverage of the individuals identified above, under the _____ Health Care Plan is subject to a pre-existing condition restriction, as explained to you previously in a form entitled, *Notice of Pre-Existing Condition Restrictions*.

We have considered the extent to which the restriction applies to the individuals listed above, and have set forth below, with respect to each such individual, the day on which the restriction will no longer apply.

Name

Restriction No Longer Applies On . . .

In making this determination we have relied upon the following information: *(List information relied upon, such as creditable coverage certificates provided with respect to the individuals; if no such certificates were provided, state "None".)*

Each individual listed above has a right to submit additional evidence of creditable coverage in order to reduce or eliminate the period for which the Plan's restriction will apply.

If you disagree with our determination as reflected on this Notice, you may appeal that determination by filing a written appeal with the office listed below. You should submit evidence demonstrating why and how our determination is incorrect. We will then notify you about our decision on appeal.

Send your written appeal to:

(Insert Office)

(Insert Address)