cooperative federal-state system to exchange such records.

The United States Attorney General appointed 15 persons from Federal and State agencies to serve on the Compact Council. The Compact Council will prescribe system rules and procedures for the effective and proper operation of the Interstate Identification Index System.

Matters for discussion are expected to include:

(1) Adam Walsh Child Protection and Safety Act of 2006.

(2) Policy Change When Applicants are Physically Incapable of Providing Fingerprints.

(3) Strategy for Increasing State Ratification of the National Crime Prevention and Privacy Compact.

The meeting will be open to the public on a first-come, first-seated basis. Any member of the public wishing to file a written statement with the Compact Council or wishing to address this session of the Compact Council should notify Mr. Todd C. Commodore at (304) 625–2803, at least 24 hours prior to the start of the session. The notification should contain the requestor's name and corporate designation, consumer affiliation, or government designation, along with a short statement describing the topics to be addressed and the time needed for the presentation. Requesters will ordinarily be allowed up to 15 minutes to present a topic.

Dates and Times: The Compact Council will meet in open session from 9 a.m. until 5 p.m., on November 7–8, 2006.

ADDRESSES: The meeting will take place at the Sheraton Oklahoma City Hotel, One North Broadway, Oklahoma City, Oklahoma, telephone (405) 235–2780.

FOR FURTHER INFORMATION CONTACT: Inquiries may be addressed to Mr. Todd C. Commodore, FBI Compact Officer, Compact Council Office, Module B3, 1000 Custer Hollow Road, Clarksburg, West Virginia 26306–0148, telephone (304) 625–2803, facsimile (304) 625–2539.

Dated: September 28, 2006.

David Cuthbertson,

Section Chief, Programs Development Section, Criminal Justice Information Services Division, Federal Bureau of Investigation.

[FR Doc. 06–8672 Filed 10–13–06; 8:45 am]

BILLING CODE 4410–02–M

DEPARTMENT OF LABOR

Office of the Secretary

Submission for OMB Review: Comment Request

October 10, 2006.

The Department of Labor (DOL) has submitted the following public information collection request (ICR) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. chapter 35). A copy of this ICR, with applicable supporting documentation, may be obtained from RegInfo.gov at *http://www.reginfo.gov/public/do/PRAMain* or by contacting Darrin King on 202–693–4129 (this is not a toll-free number)/e-mail: *king.darrin@dol.gov.*

Comments should be sent to Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for the Employment Standards Administration (ESA), Office of Management and Budget, Room 10235, Washington, DC 20503, telephone: 202–395–7316/fax: 202–395–6974 (these are not toll-free numbers), within 30 days from the date of this publication in the **Federal Register.**

The OMB is particularly interested in comments which:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Agency: Employment Standards Administration.

Type of Review: Extension without change of currently approved collection.

Title: The Secretary of Labor's Opportunity, Exemplary Voluntary Effort (EVE), and Exemplary Public Interest Contribution (EPIC) Awards.

OMB Number: 1215–0201.

Frequency: Annually.

Type of Response: Reporting.

Affected Public: Private Sector: Business and other for-profit and not-for-profit institutions.

Estimated Number of Respondents: 39.

Estimated Number of Annual Responses: 39.

Estimated Average Response Time: 114 hours.

Estimated Total Annual Burden Hours: 4,460.

Total Annualized Capital/Startup Costs: $0.

Total Annual Costs (operating/maintaining systems or purchasing services): $0.

Description: The Office of Federal Contract Compliance Programs (OFCCP) is responsible for the administration of the Secretary of Labor's Opportunity Award, Exemplary Voluntary Effort (EVE), and Exemplary Public Interest Contribution (EPIC) Awards. These Awards shall be presented annually to Federal contractors and non-profit organizations whose activities support the mission of the OFCCP. This information collection will be utilized in an effort to select recipients for the Secretary of Labor's Opportunity, EVE, and EPIC Awards.

Darrin A. King,

Acting Departmental Clearance Officer.

[FR Doc. E6–17122 Filed 10–13–06; 8:45 am]

BILLING CODE 4510–23–P

DEPARTMENT OF LABOR

Office of the Secretary

Submission for OMB Review: Comment Request

October 9, 2006.

The Department of Labor (DOL) has submitted the following public information collection requests (ICR) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. chapter 35). A copy of each ICR, with applicable supporting documentation, may be obtained from RegInfo.gov at *http://www.reginfo.gov/public/do/PRAMain* or by contacting Darrin King on 202–693–4129 (this is not a toll-free number)/e-mail: *king.darrin@dol.gov*.

Comments should be sent to Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for the Employee Benefits Security Administration (EBSA), Office of Management and Budget, Room 10235, Washington, DC 20503, telephone: 202–395–7316 / fax: 202–395–6974 (these are

not toll-free numbers), within 30 days from the date of this publication in the **Federal Register**.

The OMB is particularly interested in comments which:

• Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

• Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

• Enhance the quality, utility, and clarity of the information to be collected; and

• Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Agency: Employee Benefits Security Administration.

Type of Review: Extension without change of currently approved collection.

Title: Notice of Special Enrollment Rights under Group Health Plans.

OMB Number: 1210–0101.

Frequency: On occasion.

Type of Response: Third party disclosure.

Affected Public: Private Sector: Business or other for-profit and not-for-profit institutions.

Number of Respondents: 2,493,046.

Number of Annual Responses: 8,568,282.

Total Burden Hours: 1.

Total Annualized Capital/Startup Costs: $0.

Total Annual Costs (operating/maintaining systems or purchasing services): $77,115.

Description: Section 734 of the Employee Retirement Income Security Act (ERISA), which was added by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191, Aug. 21, 1996) (HIPAA), gives the Secretary of Labor, in coordination with the Secretary of Health and Human Services (HHS) and the Secretary of the Treasury, (collectively, the Departments) the authority to promulgate necessary or appropriate regulations to carry out the provisions of Part 7 of ERISA (the HIPAA provisions). Among other things, the HIPAA provisions limit the extent to which group health plans and their health insurance issuers can restrict health coverage based on pre-existing conditions for individuals who previously had health coverage. Section 701(f) of ERISA also provides special enrollment rights to individuals who have previously declined health coverage offered to them to enroll in health coverage upon the occurrence of specified events, including when they lose other coverage, when employer contributions to the cost of other coverage cease, and when they marry, have a child or adopt a child (''special enrollment events''). Plans and issuers are required to provide for 30-day special enrollment periods following any of these events during which individuals who are eligible but not enrolled have a right to enroll without being denied enrollment or having to wait for a late enrollment opportunity (often called ''open enrollment'').

The Departments issued Interim Final Rules for Health Insurance Portability for Group Health Plans on April 8, 1997 (67 FR 16894), and Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers under HIPAA Titles I & IV on December 30, 2004 (69 FR 78720). The implementing regulations require plans and their issuers to provide all employees a notice describing the special enrollment rights at or before the time the employees are initially offered the opportunity to enroll in the plan, whether or not they enroll. The Departments believe that the special enrollment notice is necessary to ensure that employees understand their enrollment options and will be able to exercise their rights during any 30-day enrollment period following a special enrollment event. The final regulations provide detailed sample language describing special enrollment rights for use in the notice. The sample language is expected to reduce costs for group health plans since it eliminates the need for plans to develop their own language.

Under the HIPAA provisions, a group health plan may require, as a pre-condition to having a special enrollment right to enroll in group health coverage after losing eligibility under other coverage, that an employee or beneficiary who declines coverage provide the plan a written statement declaring whether he or she is declining coverage because of having other coverage. Failure to provide such a written statement can then be treated as eliminating the individual's later right to special enrollment upon losing eligibility for such other coverage. The implementing regulations further establish that the right to special enroll can be denied in such circumstances only if employees are given notice of the requirement for a written statement and the consequences of failing to provide the written statement, at the time an employee declines enrollment. As part of the special enrollment notice, it must be given at or before the time the employee is initially offered the opportunity to enroll.

This information collection request (ICR) covers the requirement in the implementing regulations under section 701(f) for a special enrollment notice.

This information collection implements the disclosure obligation of a plan to inform all employees, at or before the time they are initially offered the opportunity to enroll in the plan, of the plan's special enrollment rules. The regulations require plans and their issuers to provide all employees with a notice describing their special enrollment rights, whether or not they enroll. This provision is necessary to make sure that employees are informed of their special enrollment rights before they take any action that may affect those rights, so that they will be able to aware of and able to exercise their rights within any 30-day enrollment period following a special enrollment event. Absent the notice requirement, there is a risk that employees will not know in advance that they have special enrollment rights and will not be able to take timely action to enroll in group health coverage following a special enrollment event.

Agency: Employee Benefits Security Administration.

Type of Review: Extension without change of currently approved collection.

Title: Notice of Pre-Existing Condition Exclusion Under Group Health Plans.

OMB Number: 1210–0102.

Frequency: On occasion.

Type of Response: Third party disclosure.

Affected Public: Private Sector: Business or other for-profit and Not-for-profit institutions.

Number of Respondents: 747,914.

Number of Annual Responses: 3,832,337.

Total Burden Hours: 5,714.

Total Annualized Capital/Startup Costs: $0.

Total Annual Costs (operating/maintaining systems or purchasing services): $1,120,709.

Description: Section 734 of the Employee Retirement Income Security Act (ERISA), which was added by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191, Aug. 21, 1996) (HIPAA), gives the Secretary of Labor, in coordination with the Secretary of Health and Human Services (HHS) and the Secretary of the Treasury, (collectively, the Departments) the authority to

promulgate necessary or appropriate regulations to carry out the provisions of Part 7 of ERISA (the HIPAA provisions).

The portability provisions of Part 7 limit the extent to which group health plans and their health insurance issuers can restrict health coverage based on pre-existing conditions for individuals who previously had health coverage and make it easier for such individuals to continue their health coverage when they change jobs by limiting the ability of group health plans and health insurance issuers to exclude coverage based on a pre-existing condition. The provisions limit all pre-existing condition exclusion periods to twelve months (or eighteen months for certain individuals who enroll late in the plan). Further, a group health plan must reduce the twelve- or eighteen-month exclusion period by the length of an individual's previous ''continuous health coverage.'' Continuous health coverage, in this context, means health coverage without any significant breaks in coverage. A significant break in coverage is any period without coverage that lasts for 63 days or more. Following a significant break in coverage, an individual is not entitled to any credit for prior coverage to reduce a preexisting condition exclusion period.

The Departments issued Interim Final Rules for Health Insurance Portability for Group Health Plans on April 8, 1997 (67 FR 16894), and Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers under HIPAA Titles I & IV on December 30, 2004 (69 FR 78720). *See* 29 CFR 2590.701–1 through 701–7. These regulations impose certain information collection and other requirements mandated by portability provisions enacted in Section 701 of HIPAA.

In order to offset burdens on plans and issuers, the regulations require participants to demonstrate their prior creditable coverage in some circumstances. In order to help balance the burdens shifted to the participants, the regulations provide the following protections relating to providing prior creditable coverage and preexisting condition exclusions:

General Notice

Plans and issuers that impose preexisting condition exclusion periods must give employees eligible for coverage, as part of any enrollment application, a general notice that describes the plan's preexisting condition exclusion, including that the plan will reduce the maximum exclusion period by the length of an employee's prior creditable coverage. If there are no such enrollment materials, the notice must be provided as soon after a request for enrollment as is reasonably possible. The final regulation includes sample language for the general notice. *See* 29 CFR 2590.701–3(c). This language is likely to reduce the cost of providing the notice.

Plans that use the alternative method of crediting coverage provided in the regulations must disclose their use of that method at the time of enrollment and describe how it operates. They must also explain that a participant has a right to establish prior creditable coverage through a certificate or other means and to request a certificate of prior coverage from a prior plan or issuer. Finally, plans or issuers must offer to assist the participant in obtaining a certificate from prior plans or issuers, if necessary. *See* 29 CFR 2590.701–4(c)(4).

Individual Notice

Before a plan or issuer may impose a preexisting condition exclusion on a particular participant or dependent, it must give the individual written notice describing the length of the preexisting condition exclusion that will be imposed and the length of offsetting prior coverage the plan has recognized (individual notice). The individual notice must also describe the basis for the plan's decision regarding prior creditable coverage, an explanation of the individual's right to submit additional evidence of creditable coverage, and any appeal procedure established by the plan or issuer. The notice need not identify any medical conditions that could be subject to the exclusion.

The general notice and the individual notice both protect individuals by informing them of their Part 7 rights, enabling them to take any necessary corrective action, exercise their rights, and to understand the plan's provisions and how they plan to his or her personal situation.

The information collections covered by this ICR are mandated third party disclosures of information by group health plans and issuers to individuals eligible for group health coverage and/or participants in such plans against whom preexisting condition exclusions may be imposed. The information is necessary to enable individuals to understand and exercise their rights under Part 7 of ERISA. No information is required to be provided to the government under these regulations.

Agency: Employee Benefits Security Administration.

Type of Review: Extension without change of currently approved collection.

Title: Establishing Creditable Coverage under Group Health Plans.

OMB Number: 1210–0103.

Frequency: On occasion.

Type of Response: Third party disclosure.

Affected Public: Private Sector: Business or other for-profit and Not-for-profit institutions.

Number of Respondents: 2,493,046.

Number of Annual Responses: 16,250,284.

Total Burden Hours: 75,306.

Total Annualized Capital/Startup Costs: $0.

Total Annual Costs (operating/maintaining systems or purchasing services): $11,456,011.

Description: Section 734 of the Employee Retirement Income Security Act (ERISA), which was added by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191, Aug. 21, 1996) (HIPAA), provides that the Secretary of Labor, in coordination with the Secretary of Health and Human Services (HHS) and the Secretary of the Treasury, (collectively, the Departments) may promulgate such regulations (including interim final rules) as may be necessary or appropriate to carry out the provisions of Part 7 of ERISA (the HIPAA provisions). In addition, section 701(e)(3) of ERISA, added by HIPAA (with parallel provisions added to the Public Health Service Act (PHSA) and the Internal Revenue Code (the Code)), requires that the Secretary of Labor issue rules to ensure that group health plans, health insurance issuers, and other specified entities provide certain required disclosures to individuals regarding their health care coverage in order to prevent adverse effects on the individual's subsequent health coverage. These required disclosures include individual certifications of prior health coverage (certificates) and, upon the request of a plan that counts or ''credits'' prior health coverage in determining subsequent coverage for specific categories of benefits, additional information about coverage under these categories of benefits (called the ''alternative method'' of crediting coverage).

In order to effectuate these and other purposes, the Department issued Interim Final Rules for Health Insurance Portability for Group Health Plans on April 8, 1997 (62 FR 16894), and Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers under HIPAA Titles I & IV on December 30, 2004 (69 FR 78720) (final HIPAA portability regulations). The HIPAA portability provisions limit the extent to

which group health plans and their health insurance issuers can restrict health coverage based on preexisting conditions for individuals that were previously covered by health coverage. The provisions limit all preexisting condition exclusion periods to twelve months, or eighteen months for certain individuals who enroll in the plan after their initial opportunity to enroll. Further, the twelve- or eighteen-month exclusion period must be reduced by the length of an individual's prior continuous health coverage, as reflected in certificates or demonstrated through other means. ''Continuous health coverage'' means coverage that did not have any significant breaks in coverage. A significant break in coverage, for this purpose, is defined as a period of 63 days or more. Following a significant break in coverage, prior health coverage is no longer ''creditable,'' that is, entitled to be taken as a credit to reduce a plan's preexisting condition exclusion period.

Section 701(e) of ERISA requires group health plans and health insurance issuers to provide certificates of an individual's prior health coverage on termination of coverage, at the time an individual would lose coverage in the absence of continuation coverage (''COBRA''), and when an individual loses coverage after COBRA coverage ceases. Certificates must also be provided on request and may be requested at any time while an individual is covered by the plan and for 24 months after coverage ceases. (Certificates must also be provided by other entities that provide creditable coverage, like Medicare and Medicaid.) The certificate must show the number of days of creditable coverage earned by the individual and also include an educational statement describing the Part 7 rights. The regulations provide model language for the educational statement. In addition, the regulations require a group health plan to establish written procedures governing the process for requesting a certificate.

The individual who receives a certificate may present it to his or her new group health plan in order to receive credit for prior health coverage under the new plan. The certificate provides assurance to the individual's new group health plan or its health insurance issuer that the individual had health coverage for a certain number of days that should be credited toward reducing any preexisting condition exclusion periods under the new health plan.

Because participants may be required to demonstrate creditable coverage and the status of their dependents in some circumstances in order to assert rights under Part 7, the regulations provide the following protections:

(a) If an individual is required to demonstrate dependent status, the plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status, and the individual cooperates with the plan's or issuer's efforts to verify the dependent status. (*See* 29 CFR 2590.701–5(a)(5)(ii).)

(b) A plan is required treat an individual as having furnished a certificate if the individual attests to the period of creditable coverage, presents relevant corroborating evidence, and cooperates with the plan's efforts to verify the individual's coverage. (*See* 29 CFR 2590.701–5(c).)

This ICR also covers an information collection requirement imposed under the regulations in connection with the alternative method of crediting coverage established by the regulations. The regulations permit a plan to adopt, as its method of crediting prior health coverage, provisions that impose different preexisting condition exclusion periods with respect to different categories of benefits, depending on prior coverage in that category. In such a case, the regulations require former plans to provide additional information upon request to new plans in order to establish an individual's length of prior creditable coverage within that category of benefits.

This information collection implements statutorily prescribed requirements necessary to permit individuals to establish prior creditable health coverage and to enable group health plans and issuers to verify creditable coverage. Group health plans and the plans' health insurance issuers are required to issue certificates as proof of prior creditable health coverage. These certificates assist individuals in retaining prior health coverage upon changes in employment or in other circumstances when coverage end and enable plans. A model certificate, which includes a model educational statement (''Statement of HIPAA Rights''), appears in the Final Regulations. The model certificate contains the minimum information required for such a certification. The information is used by participants in group health plans and by group health plans and health coverage issuers to establish an individual's rights to group health coverage under Part 7.

Darrin A. King,

Acting Departmental Clearance Officer.

[FR Doc. E6–17123 Filed 10–13–06; 8:45 am]

BILLING CODE 4510–29–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–59,820]

Airfoil Technologies International—Ohio; A Subsidiary Of Airfoil Technologies International, LLC; Mentor, OH; Notice of Revised Determination on Reconsideration

By letter dated August 25, 2006, the United Steel Workers, Local 1–826 (the Union), requested administrative reconsideration regarding the Department's Negative Determination Regarding Eligibility to Apply for Worker Adjustment Assistance, applicable to the workers of the subject firm. The determination for Airfoil Technologies International—Ohio, A Subsidiary of Airfoil Technologies International, LLC, Mentor, Ohio was issued on August 7, 2006. The Notice of determination was published in the **Federal Register** on August 28, 2006 (71 FR 50947). The denial was issued based on the Department's finding that the subject workers do not produce an article as required by the Trade Act of 1974. Workers are engaged in the remanufacturing of jet engine components as a service to commercial airlines, original equipment manufacturers and the military.

In the request for reconsideration, the Union alleges that the subject workers are engaged in the production of an article and that production shifted from the subject facility to an affiliated facility in Singapore.

During the reconsideration investigation, the subject company provided new information that the subject workers do not service jet engine components only; rather, the subject workers repair and remanufacture fan blades. The new information also revealed that a meaningful portion of the fan blades are produced for sale rather than repair. Workers who repair fan blades are not separately identifiable from workers who remanufacture fan blades.

The subject company also confirmed that the subject facility began closure procedures in 2006 and that fan blade production is shifting to an affiliated