BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.

HMO Louisiana, Inc.
A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

Southern National Life Insurance Company, Inc.
A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

❑ EMPLOYEE ENROLLMENT ❑ EMPLOYEE CHANGE FORM

PLEASE PRINT AND COMPLETE IN BLACK INK ONLY

SECTION A - COVERAGE SELECTIONS

Blue Cross and Blue Shield of Louisiana
- ❑ PPO (Ded/Coins.) _____
- ❑ TrueBlue (Ded/Coins.) _____
- ❑ Blue*Saver* (Ded/Coins.) _____
- ❑ Premier Blue (Plan #) _____
- ❑ Dental

HMO Louisiana, Inc.
- ❑ HMO (Plan #) _____
- ❑ POS (Plan #) _____

LABI
- ❑ Yes
- ❑ No

Southern National Life Insurance Company, Inc.
- ❑ Life/AD&D
- ❑ Dependent Life
- ❑ Short Term Disability

SECTION B - EMPLOYEE INFORMATION

ENROLLEE'S LAST NAME	FIRST	MI	SEX (M/F)	BIRTHDATE (MM/DD/YYYY)	HIRE DATE	OCCUPATION	SOCIAL SECURITY NUMBER

MAILING ADDRESS	CITY	STATE	ZIP	E-MAIL ADDRESS	HOME PHONE	WORK PHONE

MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ OTHER (explain below)	RETIRED ❑ YES ❑ NO	DATE RETIRED	EMPLOYER NAME

SECTION C - ENROLLMENT EVENTS

ENROLLMENT **Requested Effective Date** ____/____/____

❑ New ❑ Late ❑ Rehire ❑ Special Enrollee (Go to Qualifying Event Section Below.)

Class (Select One): ❑ Active ❑ Management ❑ Non-Management ❑ Retiree ❑ COBRA/State Continuation* ❑ Other

*Please complete form 23XX0500 for BCBSLA products and form 03100 00081 for HMO products.

I am enrolling for:

❑ **Health**: ❑ Employee Only ❑ Employee & Spouse ❑ Employee & Dependent Child(ren) ❑ Employee and Family ❑ I Decline

❑ **Dental**: ❑ Employee Only ❑ Employee & Spouse ❑ Employee & Dependent Child(ren) ❑ Employee and Family ❑ I Decline

❑ **Life**: ❑ Employee Only ❑ Employee & Spouse ❑ Employee & Dependent Child(ren) ❑ Employee and Family ❑ I Decline

WAIVER OF COVERAGE

I decline to enroll for this coverage due to:

❑ Spouse's Employer Plan

❑ Individual Plan ❑ Medicare

❑ COBRA from Prior Employer

❑ VA Eligibility ❑ Medicaid ❑ Tri-Care

❑ Other _____

If waiving all coverages, please go to Section I, read and sign.

CHANGE (Please complete Section E) **Requested Effective Date** ____/____/____

Type of Change: ❑ Name ❑ Address ❑ Add Dependent ❑ Delete Dependent ❑ Subgroup ❑ Class ❑ Cancellation ❑ Qualifying Event (Complete next section)

QUALIFYING EVENT ❑ Marriage ❑ Birth ❑ Adoption ❑ Placement for Adoption **Date of Qualifying Event Date** ____/____/____

If you lost other coverage, was it due to: ❑ Divorce ❑ Death ❑ Termination or reduction in work hours ❑ Employer contributions for coverage ended ❑ Other _____ (Refer to instruction page)

❑ COBRA coverage exhausted

SECTION D - EMPLOYER INFORMATION (TO BE COMPLETED BY THE EMPLOYER)

The information below must be completed by the Employer if an employee is making a change, or if the employee is canceling coverage.

Employer Name _____ Employer Signature _____ Date ____/____/____ Group/Subgroup Number ____/____

Product Selection Change (please refer to instruction page) _____ Subgroup Change: Move From _____ Move To _____

Cancellation of Coverage: ❑ Cancel Coverage (reason) _____ Last Date of Employment ____/____/____

Class Change To: ❑ Active ❑ Management ❑ Non-Management ❑ COBRA/State Continuation* ❑ Retiree ❑ Other (Explain) _____

*Note: If choosing COBRA or Louisiana State Continuation, please complete form 23XX0500 for BCBSLA products or 03100 00081 for HMOLA products.

NOTICE FOR ENROLLEES ON HMO PLANS THAT DO NOT CONTAIN A POINT-OF-SERVICE BENEFIT: 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, WHEN THOSE HEALTH CARE SERVICES AND DRUGS REQUIRE AN AUTHORIZATION BY THE PLAN

Enrollee's Last Name ______ Enrollee's First Name ______ Enrollee's ID Number ______ Group Number/Subgroup ____ / ____

SECTION E - FAMILY MEMBERS TO BE ENROLLED, CHANGED OR DELETED

ENROLL, CHANGE OR DELETE (Please circle the appropriate answer)	DEPENDENT'S FULL NAME (LAST, FIRST, MI)	RELATIONSHIP (If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered attach a copy of the order.)	BIRTHDATE	SOCIAL SECURITY NUMBER	LIVES WITH YOU IF "NO" GIVE ADDRESS/ LOCATION**	MENTALLY OR PHYSICALLY INCAPACITATED***	OUT OF AREA DEPENDENT/ STUDENT
E C D	SPOUSE	❑ HUSBAND ❑ WIFE			N/A	N/A	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ______			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ______			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ______			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ______			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ______			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO

**Address/Location ______

***If your dependent is mentally or physically incapacitated, please provide the following medical documentation from your doctor:
- Diagnosis of condition(s) causing incapacitation
- Date patient/dependent first became incapacitated
- Anticipated length of incapacitation
- Additional information needed

SECTION F - LIFE INSURANCE INFORMATION

Job Title: ______ Salary: ______ ❑ Monthly ❑ Annually

PRIMARY LIFE BENEFICIARIES

LAST NAME ______ FIRST NAME ______ MI ____ DATE OF BIRTH __/__/__ RELATIONSHIP TO YOU ______ Percent ____ %

LAST NAME ______ FIRST NAME ______ MI ____ DATE OF BIRTH __/__/__ RELATIONSHIP TO YOU ______ Percent ____ %

SECONDARY LIFE BENEFICIARIES: Contingent on the above-named beneficiaries' death, please designate the following as my Life Beneficiary:

LAST NAME ______ FIRST NAME ______ MI ____ DATE OF BIRTH __/__/__ RELATIONSHIP TO YOU ______ Percent ____ %

LAST NAME ______ FIRST NAME ______ MI ____ DATE OF BIRTH __/__/__ RELATIONSHIP TO YOU ______ Percent ____ %

SECTION G - OTHER COVERAGE INFORMATION

Do you or any dependents have other health insurance? ❑ Yes ❑ No Blue Cross and Blue Shield? ❑ Yes ❑ No	Other Group? ❑ Yes ❑ No	If yes to either give:	Policyholder	Insurance Company

Has anyone on this application been covered with health benefits, including coverage with Blue Cross and Blue Shield of Louisiana, within the past 63 days? ❑ Yes ❑ No If yes, complete the information on the right. If more than one prior carrier, please provide a certificate of coverage from other carrier(s).	List Members Covered	Coverage Start Date	Coverage End Date	Prior Insurance Carrier and Policy Number	Type of Coverage (Refer to Instruction Page)
					❑ Comprehensive ❑ Limited Benefit
					❑ Comprehensive ❑ Limited Benefit
					❑ Comprehensive ❑ Limited Benefit
					❑ Comprehensive ❑ Limited Benefit
					❑ Comprehensive ❑ Limited Benefit

Are you or any of your dependents covered by Medicare? ❑ Yes ❑ No If yes, complete the information on the right.	Name	Reason	Covered by:	Dates Medicare became effective	Medicare Numbers
		❑ Over 65 ❑ Disabled ❑ End Stage Renal Disease	❑ Part A ❑ Part B ❑ Medicare Advantage ❑ Part D	A. __/__/__ B. __/__/__ C. __/__/__ D. __/__/__	A. ______ B. ______ C. ______ D. ______
		❑ Over 65 ❑ Disabled ❑ End Stage Renal Disease	❑ Part A ❑ Part B ❑ Medicare Advantage ❑ Part D	A. __/__/__ B. __/__/__ C. __/__/__ D. __/__/__	A. ______ B. ______ C. ______ D. ______

Enrollee's Last Name	Enrollee's First Name	Enrollee's ID Number	Group Number/Subgroup /

Are you or any of your dependents currently receiving disability/Workers' Comp Benefits? ❑ Yes ❑ No If yes, complete the information on the right.	Name	Date Coverage Began	Name	Date Coverage Began
		/ /		/ /
		/ /		/ /
		/ /		/ /

SECTION H - MEDICAL HISTORY

Any personal health information (PHI) obtained by Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana Inc. (HMOLA), and/or Southern National Life Insurance Company, Inc. (SNL) in connection with the enrollment form may be retained by BCBSLA, HMOLA and/or SNL and used or disclosed in connection with future underwriting/renewal efforts.

IMPORTANT! PLEASE ANSWER ALL QUESTIONS BELOW FOR ALL ENROLLEES. FOR EACH "YES" RESPONSE, PROVIDE DETAILS ON PAGE 4

Your Height: _____ Your Weight _____ Spouse's Height _____ Spouse's Weight _____

HAS ANYONE APPLYING FOR COVERAGE EVER HAD OR BEEN DIAGNOSED WITH:

1. Diabetes mellitus?	❑ Yes	❑ No	8. Abnormal blood pressure?	❑ Yes	❑ No
2. Any type of cancer?	❑ Yes	❑ No	9. Heart trouble?	❑ Yes	❑ No
3. Any blood disorder?	❑ Yes	❑ No	10. Tuberculosis?	❑ Yes	❑ No
4. A stroke (CVA)?	❑ Yes	❑ No	11. Other lung problems?	❑ Yes	❑ No
5. Circulatory problems?	❑ Yes	❑ No	12. HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC?	❑ Yes	❑ No
6. Epilepsy?	❑ Yes	❑ No			
7. Rheumatic fever?	❑ Yes	❑ No	13. Hepatitis or a liver disorder?	❑ Yes	❑ No

IN THE LAST 5 YEARS HAS ANYONE APPLYING FOR COVERAGE HAD OR BEEN DIAGNOSED WITH:

14. Asthma, bronchitis or chronic sinus trouble?	❑ Yes	❑ No	28. Female reproductive problems?	❑ Yes	❑ No
15. Allergies?	❑ Yes	❑ No	29. Pelvic pain?	❑ Yes	❑ No
16. Arthritis?	❑ Yes	❑ No	30. Gall stones or gall bladder disorder?	❑ Yes	❑ No
17. Rheumatism/Bursitis or Sciatica?	❑ Yes	❑ No	31. Abdominal pain?	❑ Yes	❑ No
18. Had any bodily deformities?	❑ Yes	❑ No	32. Ulcers, stomach, colon or other intestinal disorders, adhesions?	❑ Yes	❑ No
19. Any back/orthopedic condition or muscular diseases?	❑ Yes	❑ No	33. Any eye conditions (excluding corrective lenses)?	❑ Yes	❑ No
20. Tumors or cysts?	❑ Yes	❑ No	34. Any ear condition or impairment?	❑ Yes	❑ No
21. Kidney stones or urinary system disorders, diabetes insipidus or prostate disorders?	❑ Yes	❑ No	35. A mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation?	❑ Yes	❑ No
22. Endocrine disorder thyroid problem or goiter?	❑ Yes	❑ No	36. Candidiasis (yeast infection), herpes, syphilis, gonorrhea, condylomata acuminata (genital warts), or other sexually transmitted diseases?	❑ Yes	❑ No
23. Hemorrhoids/rectal ailments or varicose veins?	❑ Yes	❑ No			
24. A hernia?	❑ Yes	❑ No			
25. Seizures, Fainting Spells?	❑ Yes	❑ No	37. Alcohol or substance abuse, detoxification?	❑ Yes	❑ No
26. Headaches?	❑ Yes	❑ No	38. Any condition (including developmental defects or deformities) of oral cavity, jaw, facial or cranial bones, teeth and surrounding structures?	❑ Yes	❑ No
27. Irregular/excessive menstrual bleeding?	❑ Yes	❑ No			

MISCELLANEOUS:

39. Are you expecting a biological child within the next 9 months (male or female applicant)?	❑ Yes	❑ No	43. Have you, or anyone on this application, ever had any health insurance postponed, rated, ridered, declined, cancelled, or had reinstatement refused?	❑ Yes	❑ No
40. Have you, or anyone on this application, used tobacco in any form within the last 12 months?	❑ Yes	❑ No			
41. Are you presently taking medications?	❑ Yes	❑ No	44. Have you, or anyone on this application, ever had any departure from good health or any medical or surgical advice or treatment from any medical practitioner (medical doctor/surgeon, podiatrist, chiropractor, dentists/oral surgeons, etc.) in the last 5 years?	❑ Yes	❑ No
42. Are you, or anyone on this application, engaged in private flying, parachuting, hang gliding, racing, underwater diving, handling of explosive materials or hazardous wastes or materials?	❑ Yes	❑ No			

Enrollee's Last Name _____ **Enrollee's First Name** _____ **Enrollee's Number** _____ **Group Number/Subgroup** ____ /____

PROVIDE DETAILS ACCORDING TO THE MEDICAL QUESTIONNAIRE GUIDE - ATTACH ADDITIONAL PAGES IF NECESSARY

Question #	Person	Condition/Diagnosis	A	B	C	D	E	F	G

IF MEDICAL QUESTIONNAIRE IS UNAVAILABLE, PROVIDE DETAILS FOR EACH "YES" RESPONSE IN THE FORMAT BELOW. ATTACH ADDITIONAL PAGES IF NECESSARY

Question #	Person	Condition/Diagnosis	Treatment/Complications	Physician's Name	Dates Treated	Medications, Frequency, Dosage

SECTION I - COVERAGE CONDITIONS

1. I, the undersigned, do hereby enroll for coverage with Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana, Inc. (HMOLA) and/or Southern National Life Insurance Company, Inc. (SNL) for myself and any family members listed on this enrollment form. I understand that this enrollment/change form, together with the certificate of coverage, any riders and endorsements issued by Companies, constitute my only agreement with Companies. I understand that the contract as it pertains to me and my dependent(s) will be terminated within three years of the original effective date of coverage and all fees, less claims paid, will be refunded if I committed fraud or made and intentional misrepresentation of material fact in this enrollment/change form.
2. I authorize any employer having information available as to employment, or other insurance coverage, regarding me or other family members proposed for coverage(s), to give the information to Companies or any agent acting on Companies' behalf. I understand this information will be used by the companies to determine eligibility or other related decisions deemed necessary for insurance coverage. I agree that a photographic copy of this authorization is as valid as the original. I hereby request the health coverage provided from time to time by my employer's group health plans, and I authorize deduction from my pay the amounts, if any, as may be necessary. The information given on this application is true and correct to the best of my knowledge and belief.
3. I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be eligible to enroll myself or my dependents provided that I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.
4. I acknowledge if I am eligible for Medicare, by reason of age, I have received a copy of "The Guide to Health Insurance For People With Medicare."
5. IT IS A DEPENDENT'S RESPONSIBILITY TO APPLY FOR CONTINUOUS COVERAGE ON A SEPARATE CONTRACT/CERTIFICATE WHEN ELIGIBILITY CEASES.
6. **FRAUD STATEMENT -** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment form or application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
7. All of the questions in this application and in the health history section have been read by or to me and the answers provided by the enrollee and/or dependent(s) if any, are true and correct to the best of my knowledge and belief.

X _____ Date _____

Enrollee's Signature **Enrollee's Signature Date**

OFFICE USE ONLY

01 _____ 02 _____ 03 _____ 04 _____

SUBSCRIBER ID NUMBER	GROUP NO.	SUBGROUP	CL	PRODUCT ID	HEALTH OED	WC	UW INT. HLTH. DT.	DENT. TY/CL	DENT. WC	LIFE OED	LIFE CL

LIFE COV.	BASIC	SUPP	**MEDICALLY UNDERWRITE:**	❑ BASIC LIFE	❑ SUPP. LIFE	❑ HEALTH	LIFE CODE	OUT OF ELIG.? ❑ YES ❑ NO	BASIC ELIG AMT.	BASIC GI AMT.	SUPP. ELIG. AMT.	SUPP. GI. AMT.

Attach additional pages if necessary