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

Group Number/Subgroup /

SECTION A - COVERAGE SELECTIONS

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

Vision ❑ Group Plan#_____ ❑ Voluntary Plan#_____

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

LABI
- ❑ Yes
- ❑ No

Southern National Life Insurance Company, Inc.
- ❑ Group Term Life
- ❑ Short Term Disability with Life
- ❑ Long Term Disability
- ❑ Voluntary Short Term Disability
- ❑ Voluntary Long Term Disability
- ❑ Voluntary Life
- ❑ Voluntary High Limit AD&D

SECTION B - EMPLOYEE INFORMATION

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

MAILING ADDRESS	CITY	STATE	ZIP	E-MAIL ADDRESS	ANNUAL SALARY

MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ OTHER _____	RETIRED ❑ YES ❑ NO	DATE RETIRED	EMPLOYER NAME	PRIMARY LANGUAGE SPOKEN IN THE HOME	HOME PHONE	WORK PHONE

SECTION C - ENROLLMENT EVENTS

ENROLLMENT **Requested Effective Date** ____/____/____ **Group #** _____ ❑ New ❑ Late ❑ Rehire ❑ Special Enrollee (Go to Qualifying Event Section Below.)

Class (Select One): ❑ Active ❑ Management ❑ Non-Management ❑ Retiree ❑ Other _____

Please check all that apply. Benefit options are dependent upon employer elections. I am enrolling for:

	Health	Dental	Vision	Group Life	STD	LTD	Voluntary Life	Vol STD	Vol LTD	Vol High Limit & AD&D
Employee (EE)	❑	❑	❑	❑	❑	❑	❑ $_____ ❑ _____ times salary	❑	❑	❑ $_____
Spouse (SP)	❑	❑	❑				❑ Voluntary SP coverage $_____			
Dependent Child(ren)	❑	❑	❑				❑ Voluntary CH			
Family	❑	❑	❑	❑						❑
I Decline	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

WAIVER OF MEDICAL COVERAGE **I decline to enroll for this coverage due to:**

❑ Spouse's Group Employer Plan Plan Name _____ Policy Number _____ ❑ COBRA from Prior Employer ❑ Tri-Care ❑ Retiree from Prior Employer
❑ Individual Plan ❑ Medicare ❑ Medicaid ❑ VA Eligibility ❑ Other _____ **Note:** If waiving all coverages, please go to Section J, read and sign.

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

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

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

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 or other continuation coverage exhausted

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 Number ________ Group Number/Subgroup ____/____

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.

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

Annual Salary Change From $ ________ to $ ________

Class Change From ________ To: ________

Employer Name ________ Employer Signature ________ Date ____/____/____

SECTION E - FAMILY MEMBERS TO BE ENROLLED OR CHANGED

ENROLL OR CHANGE (Please circle the appropriate answer)	DEPENDENT'S FULL NAME (LAST, FIRST, MI)	E-MAIL	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			❑ HUSBAND ❑ WIFE			N/A	N/A	❑ YES ❑ NO
E C			❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ____			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C			❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ____			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C			❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ____			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C			❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ____			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C			❑ 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

E-mail addresses are being collected to enable our Companies to communicate with you electronically. Once enrolled for coverage, you will be able to manage your communication preferences. Minors will not receive electronic communications directly, however, if contact information for a legally responsible party is provided for a minor, that individual may receive electronic communications on behalf of the minor.

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

SECTION F - LIFE & DISABILITY INSURANCE INFORMATION

Noted beneficiaries apply to all life products selected

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 ____%

Last Name _____ First Name _____ MI ____ Date of Birth __/__/__ Relationship to you _____ Percent ____%

_____ Total 100%

CONTINGENT ON THE ABOVE-NAMED BENEFICIARIES' DEATH, PLEASE DESIGNATE THE FOLLOWING AS MY SECONDARY 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 ____%

_____ Total 100%

SECTION G - OTHER COVERAGE INFORMATION

Do you or any Dependents have other health insurance? ❑ Yes ❑ No Other Group? ❑ Yes ❑ No If yes to either give: Policyholder Insurance Company

BCBSLA or HMOLA? ❑ Yes ❑ No

Has anyone on this application been covered with health benefits, including coverage with BCBSLA or HMOLA, 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.
Please provide a clear copy of the Medicare card.

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. _____

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
	/ /		/ /
	/ /		/ /
	/ /		/ /

(Continue to next page)

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

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. (SNLIC) in connection with the enrollment form may be retained by BCBSLA, HMOLA and/or SNLIC 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 5

For life and disability coverage: If applying only for life and disability coverage as a Late Applicant or for a benefit above the Guarantee Issue amount, you are required to answer medical questions indicated with an * only.

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. Have or had 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 any 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. Had any female reproductive problems or female infertility?	❑ 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. Had any back and/or orthopedic condition or muscular diseases, back pain or joint pain?	❑ Yes	❑ No	33. Any eye conditions (excluding corrective lenses)?	❑ Yes	❑ No
			34. Any ear condition or impairment?	❑ Yes	❑ No
*20. Had any tumors, cysts or growths?	❑ Yes	❑ No	*35. A mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation?	❑ Yes	❑ No
*21. Kidney stones or urinary system disorders, diabetes insipidus or prostate disorders?	❑ Yes	❑ No	*36. Candidiasis (yeast infection), herpes, syphilis, gonorrhea, condylomata acuminata (genital warts), or other sexually transmitted diseases?	❑ Yes	❑ No
22. Endocrine disorder thyroid problem or goiter?	❑ Yes	❑ No			
23. Hemorrhoids/rectal ailments or varicose veins?	❑ Yes	❑ No			
24. A hernia?	❑ Yes	❑ No	*37. Alcohol or substance abuse, detoxification?	❑ Yes	❑ No
*25. Seizures, Fainting Spells?	❑ Yes	❑ No	38. Any condition (including developmental defects or deformities) of oral cavity, jaw, facial or cranial bones, teeth and surrounding structures?	❑ Yes	❑ No
*26. Headaches?	❑ 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, life or disability 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 - PRIMARY CARE PHYSICIAN (PCP) SELECTION (complete if enrolling in Community Blue or BlueConnect products)

Enrollee Name	Social Security Number	Physician Name	Physician Address

If you do not select a PCP, one will be selected for you.

SECTION J - 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. (SNLIC) 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 an 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 spouse), I may in the future be able to enroll myself or my Dependents in these plans, provided that I request enrollment within 30 days of the qualifying event. 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**

If enrolling for Community Blue or Blue Connect, have you selected a PCP?

OFFICE USE ONLY								
	HEALTH EFFECTIVE DATE	WC	UW INT. HLTH. DT.		GTL		VGTL	
	DENTAL	VISION	LTD	STD	VLTD	VSTD	SUPP LIFE	OUT OF ELIG.? ❑ YES ❑ NO

Attach additional pages if necessary