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.) ______ ❑ Dental
❑ Premier Blue (Plan #) ______ ❑ BlueSaver (Ded/Coins.) ______

HMO Louisiana, Inc.
❑ HMO (Plan #) ______
❑ POS (Plan #) ______

Southern National Life Insurance Company, Inc.
❑ Life ❑ Dependent Life

LABI ❑ Yes ❑ No

For BlueSaver only: Please open an account with MySmartSaver Health Savings Account (HSA). ❑ Yes ❑ No
Send Spouse information from Section E as an authorized signer on MySmartSaver Health Savings Account (HSA). ❑ Yes ❑ No

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 (must provide street address for HSA setup)	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 ❑ COBRA coverage exhausted ❑ Other ______ (Refer to instruction page)

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.

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	DEPENDS ON YOU FOR SUPPORT. IF YES, DATE DEPENDENCY BEGAN	FULL-TIME STUDENT*	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	N/A	N/A	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ____			❑ YES ❑ NO / /	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ____			❑ YES ❑ NO / /	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ____			❑ YES ❑ NO / /	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ____			❑ YES ❑ NO / /	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO

*If your dependent is a full-time student, please provide the following: Name of School: ______ School Address: ______

Original Enrollment Date: ______ Expected Date of Graduation: ______ Current Term: From ______ To ______

**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
- Anticipated length of incapacitation
- Date patient/dependent first became incapacitated
- 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, Inc. 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
2. Any type of cancer? ❑ Yes ❑ No
3. Any blood disorder? ❑ Yes ❑ No
4. A stroke (CVA)? ❑ Yes ❑ No
5. Circulatory problems? ❑ Yes ❑ No
6. Epilepsy? ❑ Yes ❑ No
7. Rheumatic fever? ❑ Yes ❑ No
8. Abnormal blood pressure? ❑ Yes ❑ No
9. Heart trouble? ❑ Yes ❑ No
10. Tuberculosis? ❑ Yes ❑ No
11. Other lung problems? ❑ Yes ❑ No
12. HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC? ❑ 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
15. Allergies? ❑ Yes ❑ No
16. Arthritis? ❑ Yes ❑ No
17. Rheumatism/Bursitis or Sciatica? ❑ Yes ❑ No
18. Had any bodily deformities? ❑ Yes ❑ No
19. Any back/orthopedic condition or muscular diseases? ❑ Yes ❑ No
20. Tumors or cysts? ❑ Yes ❑ No
21. Kidney stones or urinary system disorders, diabetes insipidus or prostate disorders? ❑ 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
25. Seizures, Fainting Spells? ❑ Yes ❑ No
26. Headaches? ❑ Yes ❑ No
27. Irregular/excessive menstrual bleeding? ❑ Yes ❑ No
28. Female reproductive problems? ❑ Yes ❑ No
29. Pelvic pain? ❑ Yes ❑ No
30. Gall stones or gall bladder disorder? ❑ Yes ❑ No
31. Abdominal pain? ❑ Yes ❑ No
32. Ulcers, stomach, colon or other intestinal disorders, adhesions? ❑ Yes ❑ No
33. Any eye conditions (excluding corrective lenses)? ❑ Yes ❑ No
34. Any ear condition or impairment? ❑ Yes ❑ No
35. A mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation? ❑ Yes ❑ No
36. Candidiasis (yeast infection), herpes, syphilis, gonorrhea, condylomata acuminata (genital warts), or other sexually transmitted diseases? ❑ Yes ❑ No
37. Alcohol or substance abuse, detoxification? ❑ Yes ❑ No
38. Any condition (including developmental defects or deformities) of oral cavity, jaw, facial or cranial bones, teeth and surrounding structures? ❑ Yes ❑ No

MISCELLANEOUS:

39. Are you expecting a biological child within the next 9 months (male or female applicant)? ❑ 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
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
43. Have you, or anyone on this application, ever had any health insurance postponed, rated, ridered, declined, cancelled, or had reinstatement refused? ❑ 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

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 membership in Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana, Inc. (HMOLA) and/or Southern National Life Insurance Company, Inc. (SNL) for myself and family members, if any, listed on this enrollment form. I understand that this enrollment/change form and contract, together with any riders and endorsements issued by BCBSLA, constitute my only agreement with BCBSLA, HMOLA and/or SNL. If the enrollment form is accepted, a certificate will be issued. 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 a material misrepresentation of fact as to my dependents and me exists in the 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 BCBSLA, HMOLA and/or SNL or any agent acting on BCBSLA, HMOLA and/or SNL's behalf. I understand this information will be used by BCBSLA, HMOLA. and/or SNL 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 herein 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 the health history section have been read by or to me and the answers given are provided by the enrollee and/or dependent(s) if any.

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

Instructions for Enrollee/Change Form

Please read thoroughly before completing the enrollment application/change form. Be sure to complete the enrollee information on the top of each page. Any incomplete forms will be returned for completion.

Check either "Employee Enrollment" or "Employee Change Form."

	Employers *For all employees, including new hires, the top of pages 2 thru 4 must be completed in full.* *Enrollment and New Hires: Enrollee's ID Number will their social security number and Group Number/Subgroup must be identified* *Changes: Enrollee's ID Number will their employee's member number and Group Number/Subgroup must be identified*

Section A Coverage Selections	• **Select** medical, dental and life coverage options offered by your employer.
	• **For medical coverage**, indicate your deductible/coinsurance amounts or the medical plan number, where applicable.
	• Be sure to check "Yes" if your group is a **Louisiana Association of Business and Industry** (LABI) group. If you're not sure, check with your group leader.
	• If you have a **Blue*Saver*** plan, you must complete the Blue*Saver* box of Section A. MySmart$aver is a health savings account offered by our preferred HSA provider, Bancorp.
	  ◦ To open an HSA with Bancorp, select "Yes" for "Please open an account…."
	  ◦ If you want your spouse to be able to sign checks and use your MySmart$aver debit card, check yes on the second line, "Send Spouse information from Section E as an authorized signer…."

Section B Enrollee Information	• **If you are a new subscriber, complete the entire section**. • If you are an **established subscriber making changes or adding a dependent**, you only need to fill in your first and last name. • **Hire date:** if you are a rehire, note the date of your rehire in this section, not your original hire date. • **Marital status**: Other: Select this box if you are divorced or widowed.

Section C Enrollment Events	• **Select** "New" **if this is your group's initial enrollment with Blue Cross and/or HMO Louisiana or if you are a new hire serving eligibility.**
	• Select **"Late"** if you are enrolling during open enrollment or if you are changing products.
	• Select **"Rehire"** if you are a rehire and be sure to indicate your new hire date in Section B.
	• Select **"Special Enrollee"** if you have experienced a qualifying event and indicate the event at the bottom of Section C.
	  ◦ If you are unsure what your class is, check with your group leader.
	  ◦ For health, dental and life, check the appropriate box for the **product and coverage type** in which you are enrolling.
	  ◦ Select **"I decline"** for the product(s) in which you are not enrolling.
	  ◦ Complete the **"Waiver of Coverage"** box if you are waiving coverage.
	  ◦ For a change of status, mark the appropriate box under "Change" of Section C. Indicate your qualifying event, if applicable, and be sure to give the day, month and year of the event.

Section	Instructions
Section D Employer Information	***To Be Completed By Employer*** • Group Leaders must complete this section if an employee is **MAKING A CHANGE** or if the **EMPLOYEE** is **CANCELING** coverage. • The group leader's signature is required for any changes indicated in this section. • **Product Selection Change:** If your group offers more than one medical plan and an employee is changing plans during open enrollment. You may need to also change the class of the employee. • **Subgroup Change:** If your group has billing set up for multiple locations or divisions and an employee is changing locations, the employee will be changing subgroups. Based on your billing subgroup number, indicate the subgroup they are moving from and the subgroup they are moving to. You may need to also change the class of the employee. • **Cancellation of Coverage**: Provide the reason the employee is canceling coverage and the last date of employment. • **Class Change**: Changes may result in a change to the employee's classification. Indicate the new class. A terminating employee will need COBRA or State Continuation class change indicated.
Section E Family Members	• In the first column, indicate the family members who are **enrolling (E), changing (C)** or **deleting (D).** • Complete each applicable section in full. • An **out-of-area dependent** is a dependent who lives out-of-state.
Section F Life Insurance Information	• If you are **splitting your life insurance** among beneficiaries, you must indicate the percentage that should go to each beneficiary. • If you do not indicate a beneficiary, the beneficiary will automatically be designated as the "**estate of.**"
Section G Other Coverage Information	**Complete this section only if you or your dependents have other coverage.** • Please give the complete names of your dependents. We cannot accept "mother," "daughter," etc. • Type of Coverage: **Comprehensive** coverage includes a full-coverage employer sponsored or individually owned health insurance plan. **Limited Benefit** coverage includes an employer sponsored or individually owned policy which is specific in the type of coverage provided. For example dental, vision, cancer, specific disease, hospital indemnity or a limited coverage group medical policy.
Section H Medical History	• Complete this section if required by your group. • Provide an explanation of medical conditions you checked using the Medical Questionnaire Guide. If the guide is not available, provide details in the second table listed.
Section I Coverage Conditions	• Please carefully read this section and sign and date.