BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

INDIVIDUAL HEALTH CHANGE OF STATUS CARD

HMO Louisiana, Inc.

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

AGENT'S NAME	AGENT'S NUMBER

01 _____ 02 _____ 03 _____ 04 _____

SUBSCRIBER: PLEASE COMPLETE THIS SECTION

LAST NAME (PLEASE PRINT)	FIRST NAME	M.I.	CONTRACT NO.
DAY TIME PHONE NO.	ARE YOU OR ANY OF YOUR DEPENDENTS CURRENTLY RECEIVING DISABILITY/WORKERS' COMP. BENEFITS? ❑ YES ❑ NO		SHADED AREAS FOR OFFICE USE ONLY

PLEASE CHANGE MY CONTRACT TO THE FOLLOWING

❑ SUBSCRIBER ONLY ❑ SUBSCRIBER & SPOUSE ❑ SUBSCRIBER & CHILD(REN) ❑ SUBSCRIBER, SPOUSE & CHILD(REN)

Change name to	EFFECTIVE DATE	LAST NAME	FIRST NAME	M.I.
Reason for name change				
Change address to	STREET ADDRESS		E-MAIL ADDRESS	
	CITY	STATE	ZIP CODE	

PLEASE ADD THE FOLLOWING DEPENDENTS TO MY CONTRACT (MUST ALSO COMPLETE OTHER SIDE)

DEPENDENT'S FULL NAME* (Include first, last, mi)	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YR	If adding maternity within 30 days of marriage, then please submit a copy of the marriage license.	DATE DEPENDENCY BEGAN
SPOUSE			❑ HUSBAND ❑ WIFE DATE OF MARRIAGE _____	
OLDEST CHILD			❑ SON ❑ STEPSON ❑ OTHER (Specify)_____ ❑ DAUGHTER ❑ STEPDAUGHTER	
CHILD			❑ SON ❑ STEPSON ❑ OTHER (Specify)_____ ❑ DAUGHTER ❑ STEPDAUGHTER	
CHILD			❑ SON ❑ STEPSON ❑ OTHER (Specify)_____ ❑ DAUGHTER ❑ STEPDAUGHTER	

***HAS ANY PERSON BEING ADDED HAD OTHER HEALTH COVERAGE WITHIN 63 DAYS? ❑ YES ❑ NO IF YES, PLEASE COMPLETE THE PRIOR CARRIER HEALTH COVERAGE FORM - 23XX1938.**

PLEASE DROP FOLLOWING DEPENDENTS FROM MY CONTRACT

IF DROPPING THIS DEPENDENT LEAVES ONLY THE SUBSCRIBER TO BE COVERED, PLEASE CHECK THE "SUBSCRIBER ONLY" BLOCK IN THE "CHANGE MY CONTRACT" SECTION ABOVE. IT IS A DEPENDENT'S RESPONSIBILITY TO APPLY FOR CONTINUOUS COVERAGE ON A SEPARATE CONTRACT WHEN ELIGIBILITY STOPS IN ACCORDANCE WITH THE TERMS OF THE CONTRACT.

GIVE FULL NAME	EFFECTIVE DATE	CHECK RELATIONSHIP	DATE OF BIRTH MO. DAY YR	REASON
		❑ HUSBAND ❑ WIFE		
		❑ SON ❑ DAUGHTER		
		❑ SON ❑ DAUGHTER		

PLEASE CHANGE MY BENEFITS TO THE FOLLOWING

SUBSCRIBER: PLEASE SIGN →

SUBSCRIBER'S SIGNATURE X	DATE

OFFICE USE	EFF DATE	GROUP NO.	DEPT.	SUB	CLASS/SPEC	WAV	DEN TY	DEN CL	DEN WC	CLK CD	U.W. INT.	DT. APPRVD	RIDERS/SPEC. INFORMATION
	❑ MEDICALLY UNDERWRITE				❑ OTHER						UW INITIALS		DATE

SUBSCRIBER'S LAST NAME (PLEASE PRINT)	FIRST NAME	M.I.	CONTRACT NO.

ANSWER ALL QUESTIONS BELOW FOR ALL PERSONS INCLUDED IN THIS APPLICATION. FOR EACH POSITIVE RESPONSE, UNDERLINE THE APPROPRIATE STATEMENT OR CONDITION AND COMPLETE THE MEDICAL QUESTIONNAIRE BELOW.

SUBSCRIBER'S HEIGHT:	SUBSCRIBER'S WEIGHT:	SPOUSE'S HEIGHT:	SPOUSE'S WEIGHT:

HAS ANYONE APPLYING FOR COVERAGE EVER HAD OR BEEN DIAGNOSED WITH:	YES	NO
1) Diabetes Mellitus?	❑	❑
2) Any type of Cancer?	❑	❑
3) Any blood disorder?	❑	❑
4) A stroke (CVA)?	❑	❑
5) Circulatory problems?	❑	❑
6) Epilepsy?	❑	❑
7) Rheumatic Fever?	❑	❑
8) Abnormal blood pressure?	❑	❑
9) Heart Trouble	❑	❑
10) Tuberculosis?	❑	❑
11) Have or had lung problems?	❑	❑
12) HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC?	❑	❑
13) Hepatitis or a liver disorder?	❑	❑
IN THE LAST 5 YEARS HAS ANYONE APPLYING FOR COVERAGE HAD OR BEEN DIAGNOSED WITH:		
14) Asthma, bronchitis or chronic sinus trouble?	❑	❑
15) Allergies	❑	❑
16) Arthritis?	❑	❑
17) Rheumatism/Bursitis or Sciatica?	❑	❑
18) Had any bodily deformities?)	❑	❑
19) Had any back and/or orthopedic condition or muscular diseases, back pain or joint pain?	❑	❑
20) Had any tumors, cysts or growths?	❑	❑
21) Kidney stones or urinary system disorders, diabetes insipidus or prostate disorders?	❑	❑
22) Endocrine disorder, thyroid problem or goiter?	❑	❑
23) Hemorrhoids/rectal ailments or varicose veins?	❑	❑
24) A hernia?	❑	❑
25) Seizures, Fainting Spells?	❑	❑
26) Headaches?	❑	❑
27) Irregular/excessive menstrual bleeding?	❑	❑
28) Had any female reproductive problems or female infertility?	❑	❑
29) Pelvic pain?	❑	❑
30) Gall stones or gall bladder disorder?	❑	❑
31) Abdominal pain?	❑	❑
32) Ulcers, stomach, colon or other intestinal disorders, adhesions?	❑	❑
33) Any eye conditions (excluding corrective lenses)?	❑	❑
34) Any ear condition or impairment?	❑	❑
35) A mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation?	❑	❑
36) Candidiasis (yeast infection), herpes, syphilis, gonorrhea, condylomata acuminata (genital warts), or other sexually transmitted diseases?	❑	❑
37) Alcohol or substance abuse, detoxification?	❑	❑
38) Any condition (including developmental defects or deformities) of oral cavity, jaw, facial or cranial bones, teeth and surrounding structures?	❑	❑
MISCELLANEOUS		
39) Are you expecting a biological child within the next 9 months (male or female applicant)?	❑	❑
40) Have you, or anyone on this application, used tobacco in any form within the last 12 months?	❑	❑
41) Are you presently taking medications?	❑	❑
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?	❑	❑
43) Have you, or anyone on this application, ever had any health, life or disability insurance postponed, rated, ridered, declined, canceled, or had reinstatement refused?	❑	❑
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?	❑	❑

MEDICAL QUESTIONNAIRE

PLEASE GIVE THE FOLLOWING INFORMATION FOR EACH CONDITION AND ANY OTHER PERTINENT INFORMATION.

GIVE NUMBER OF QUESTION ABOVE BEING ANSWERED	NAME	ILLNESS OR CONDITION	
DATE DIAGNOSED	DATES AND TYPES OF TREATMENT (IF MEDICATION, LIST NAME OF MEDICATION AND DOSAGE)	WAS AN OPERATION RECOMMENDED? ❑ YES ❑ NO	WAS OPERATION PERFORMED? ❑ YES ❑ NO
OPERATION OR SURGICAL PROCEDURE PERFORMED OR RECOMMENDED	DATE LAST TREATED AND CURRENT CONDITION.	IF CURRENTLY ON MEDICATION, LIST NAME OF MEDICATION AND DOSAGE	

GIVE NUMBER OF QUESTION ABOVE BEING ANSWERED	NAME	ILLNESS OR CONDITION	
DATE DIAGNOSED	DATES AND TYPES OF TREATMENT (IF MEDICATION, LIST NAME OF MEDICATION AND DOSAGE)	WAS AN OPERATION RECOMMENDED? ❑ YES ❑ NO	WAS OPERATION PERFORMED? ❑ YES ❑ NO
OPERATION OR SURGICAL PROCEDURE PERFORMED OR RECOMMENDED	DATE LAST TREATED AND CURRENT CONDITION.	IF CURRENTLY ON MEDICATION, LIST NAME OF MEDICATION AND DOSAGE	

The information given herein is true and correct, to the best of my knowledge and belief. I understand that any coverage issued is based on all statements and answers to the questions contained herein. I understand that the Contract will be terminated within three years of the original effective date of the Member's (Members') coverage and all fees, less claims paid, will be refunded if a material misrepresentation of fact as to that Member(s) exists in the application or any Change of Status Card. All of the above questions in the health history have been read by or to me and the answers given are provided by the applicant and/or dependent(s), if any.

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.

SUBSCRIBER: PLEASE SIGN →

SUBSCRIBER'S SIGNATURE X	DATE