

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	HMO Louisiana, Inc.*	Southern National Life Insurance Company, Inc.
<input type="checkbox"/> GroupCare PPO (Plan) _____	<input type="checkbox"/> HMO (Plan) _____	<input type="checkbox"/> Dental (Plan) _____
<input type="checkbox"/> BlueSaver (Plan) _____	<input type="checkbox"/> POS (Plan) _____	<input type="checkbox"/> Vision (Plan) _____
<input type="checkbox"/> Premier Blue (Plan) _____	<input type="checkbox"/> Community Blue (Plan) _____	<input type="checkbox"/> Group Term Life
<input type="checkbox"/> True Blue (Plan) _____	<input type="checkbox"/> BlueConnect HMO (Plan) _____	<input type="checkbox"/> Short Term Disability with Life <input type="checkbox"/> Voluntary Life
	<input type="checkbox"/> BlueConnect POS (Plan) _____	<input type="checkbox"/> Long Term Disability <input type="checkbox"/> Voluntary High Limit AD&D
		<input type="checkbox"/> Voluntary Short Term Disability
		<input type="checkbox"/> Voluntary Long Term Disability

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 <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	Retired from Current Employer <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Retired	Current 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:

	Medical	Dental	Vision	Group Life	STD	LTD	Voluntary Life	Company Use Only	Vol STD	Vol LTD	Vol High Limit & AD&D	Company Use Only
Employee (EE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$_____ <input type="checkbox"/> _____ (times salary)	EU ____ CL ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$_____	EU ____ CL ____
Spouse (SP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Spouse coverage \$_____	EU ____ CL ____				
Dependent Child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Child(ren)					
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	
I Decline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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 D): Requested Effective Date ____/____/____

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

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

If you lost other coverage due to: Divorce Death Termination or reduction in work hours Employer contributions for coverage ended
(Please complete Section G) Other _____ 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**

SECTION D - CHANGE 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 _____ 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
				Mo	Day	Yr				
E C			<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Domestic Partner					N/A	N/A	<input type="checkbox"/> YES <input type="checkbox"/> NO
E C			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
E C			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
E C			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
E C			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
E C			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

*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.

**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

SECTION F - LIFE INSURANCE BENEFICIARY INFORMATION

Your employer will provide you with the opportunity to elect a beneficiary or beneficiaries on a separate beneficiary designation form or system.

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

Is this a qualifying event application due to loss of other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	List Members Covered	Coverage Start Date	Coverage End Date	Prior Insurance Carrier and Policy Number	Type of Coverage (Refer to Instruction Page) <input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit
If yes, complete the information on the right. If more than one prior carrier, please provide a certificate of coverage from other carrier(s).					<input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit
					<input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit
					<input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit
					<input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit
					<input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit

Are you or any of your dependents covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	Reason <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease	Covered by: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Part D	Dates Medicare became effective A. ___/___/___ B. ___/___/___ C. ___/___/___ D. ___/___/___	Medicare Numbers A. _____ B. _____ C. _____ D. _____
If yes, complete the information on the right. Please provide a clear copy of the Medicare card.		<input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Part D	A. ___/___/___ B. ___/___/___ C. ___/___/___ D. ___/___/___	A. _____ B. _____ C. _____ D. _____
		<input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Part D	A. ___/___/___ B. ___/___/___ C. ___/___/___ D. ___/___/___	A. _____ B. _____ C. _____ D. _____

Are you or any of your Dependents currently receiving disability/workers' comp benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	Date Coverage Began / /	Name	Date Coverage Began / /
If yes, complete the information on the right.		/ /		/ /
		/ /		/ /
		/ /		/ /

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! 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 enrollee or for a benefit above the guarantee issue amount, you are required to answer medical questions indicated with an * only.
- **For Medical Coverage:** Medical questions are required for late enrollees on large groups as defined by the Affordable Care Act. Contact your Human Resources department if you are unsure of your group size.

Your Height* _____ Your Weight* _____ Spouse's Height* _____ Spouse's Weight* _____

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

*1. Diabetes mellitus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*8. Abnormal blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*2. Any type of cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*9. Heart trouble?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Any blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*4. A stroke (CVA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*11. Lung problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Circulatory problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*12. HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*6. Epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	*13. Hepatitis or any liver disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Rheumatic fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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

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

MISCELLANEOUS:

*39. Are you expecting a biological child within the next 9 months (male or female applicant)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
40. Have you, or anyone on this application, used tobacco in any form within the last 6 months including electronic cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*41. Are you presently taking medications?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Enrollee's Last Name _____ First Name _____ Subscriber 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

Recommended for all products. It is required for Community Blue or BlueConnect products. If you do not select a PCP, one will be selected for you.

Enrollee Name	Social Security Number	Physician Name	Physician Address

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. I further understand that if enrolled for coverage with Blue Cross and Blue Shield of Louisiana, HMO Louisiana, Inc. or Southern National Life Insurance Company, Inc. that the contract issued by either company constitutes a contract solely between that company and the group/policy holder and that Blue Cross Blue Shield of Louisiana, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc. are all independent corporations operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, the "Association" permitting the individual companies to use the Blue Cross and Blue Shield service marks in the state of Louisiana and that the companies are not contracting as an agent of the Association.
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**



**Have you selected a PCP? Recommended for all products.
 It is required for Community Blue or BlueConnect products.**

OFFICE USE ONLY	HEALTH EFFECTIVE DATE		UW INT. HLTH. DT.
	DENTAL	VISION	OUT OF ELIG.? <input type="checkbox"/> YES <input type="checkbox"/> NO

Attach additional pages if necessary