

EMPLOYEE ENROLLMENT **EMPLOYEE CHANGE FORM**

PLEASE PRINT AND COMPLETE IN BLACK INK ONLY

Group Number/Subgroup /

SECTION A - COVERAGE SELECTIONS

<p>Blue Cross and Blue Shield of Louisiana</p> <input type="checkbox"/> GroupCare PPO (Ded/Coins.) _____ <input type="checkbox"/> TrueBlue (Ded/Coins.) _____ <input type="checkbox"/> BlueSaver (Ded/Coins.) _____ <input type="checkbox"/> Premier Blue (Plan #) _____ <input type="checkbox"/> Dental (Plan #) _____	<p>HMO Louisiana, Inc.</p> <input type="checkbox"/> HMO (Plan #) _____ <input type="checkbox"/> POS (Plan #) _____ <input type="checkbox"/> Community Blue (Plan #) _____ <input type="checkbox"/> Blue Connect HMO (Plan #) _____ <input type="checkbox"/> Blue Connect POS (Plan #) _____	<p>LBI</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Southern National Life Insurance Company, Inc.</p> <input type="checkbox"/> Group Term Life <input type="checkbox"/> Voluntary Life <input type="checkbox"/> Short Term Disability with Life <input type="checkbox"/> Voluntary High Limit AD&D <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Voluntary Short Term Disability <input type="checkbox"/> Voluntary Long Term Disability
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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 <input type="checkbox"/> YES <input type="checkbox"/> 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	Group Life	STD	LTD	Vol Life	Vol STD	Vol LTD	Vol High Limit & AD&D
Employee (EE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____ <input type="checkbox"/> _____ times salary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____
Spouse (SP)	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> SP coverage \$ _____			
Dependent Child(ren)	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> CH			
Family	<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"/>

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

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			<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE			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

**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

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.

SECTION F - LIFE & DISABILITY INSURANCE INFORMATION

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 _____ %
 Noted beneficiaries apply to all life products selected _____ Total 100%

SECTION G - OTHER COVERAGE INFORMATION

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

Has anyone on this application been covered with health benefits, including coverage with BCBSLA or HMOLA, within the past 63 days? <input type="checkbox"/> Yes <input type="checkbox"/> 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)
					<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 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
		<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 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. (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 for life and disability coverage only, 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?	<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. Have or had 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. Had 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. Had 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. Had 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. Had 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 12 months?	<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 _____ 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.? <input type="checkbox"/> YES <input type="checkbox"/> NO

Attach additional pages if necessary