

snc

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), 71722FEF2
 TrueBlue (Ded/Coins)
 BlueSaver (Ded/Coins)
 Premier Blue (Plan #)
 Dental (Plan #)

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

~~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~~

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 RETIRED YES NO OTHER DATE RETIRED EMPLOYER NAME PRIMARY LANGUAGE SPOKEN 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"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse (SP)	<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"/>
Dependent Child(ren)	<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"/>
Family	<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"/>
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 / / 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
 (Refer to instruction page) COBRA or other continuation coverage exhausted

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			<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

**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.

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

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? Yes No Policyholder _____ Insurance Company _____
 BCBSLA or HMOLA? Yes No If yes to either give: _____

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)
				<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?
 Yes No

If yes, complete the information on the right.

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. _____

Name	Date Coverage Began	Name	Date Coverage Began
	____/____/____		____/____/____
	____/____/____		____/____/____
	____/____/____		____/____/____

Are you or any of your Dependents currently receiving disability/workers' comp benefits?
 Yes No

If yes, complete the information on the right.

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 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? 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. Have or had 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 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
- *15. Allergies? Yes No
- *16. Arthritis? Yes No
- *17. Rheumatism/Bursitis or Sciatica? Yes No
- 18. Had any bodily deformities? Yes No
- *19. Had any back and/or orthopedic condition or muscular diseases, back pain or joint pain? Yes No
- *20. Had any tumors, cysts or growths? 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
- 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
- *28. Had any female reproductive problems or female infertility? 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
- *43. Have you, or anyone on this application, ever had any health, life or disability insurance postponed, rated, rdered, 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, dentist/oral surgeons, etc.) in the last 5 years? Yes No

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 PCPP?**

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

Attach additional pages if necessary