Louisiana | HMO Louisiana | Southern National Life Insurance Company, Inc.

❑ 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 (Plan) _____
- ❑ BlueSaver (Plan) _____
- ❑ Premier Blue (Plan) _____
- ❑ True Blue (Plan) _____

HMO Louisiana, Inc.*
- ❑ HMO (Plan) _____
- ❑ Blue POS (Plan) _____
- ❑ Community Blue POS (Plan) _____
- ❑ BlueConnect POS (Plan) _____
- ❑ BlueConnect Acadiana _____

- ❑ **Dental** (Plan) _____
- ❑ **Vision** (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
- ❑ Voluntary Life
- ❑ Voluntary High Limit AD&D

SECTION B - EMPLOYEE INFORMATION

Enrollee's Last Name	First	MI	Sex (M/F)	Birthdate (MM/DD/YYYY)	Hire Date	Job Title	Social Security Number

Physical Address	City	State	Zip Code	Telephone Number	E-mail Address

Mailing Address	City	State	Zip Code	Fax Number	Annual Salary

Marital Status ❑ Married ❑ Single ❑ Other _____	Retired from Current Employer ❑ Yes ❑ No	Date Retired	Current Employer Name	Home Phone	Work Phone

SECTION C - ENROLLMENT EVENTS

ENROLLMENT **Requested Effective Date** / / **Group #** _____ ❑ New ❑ Late ❑ Rehire ❑ Special Enrollee (Go to Qualifying Event Section Below.) ❑ Open Enrollment

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)	❑	❑	❑	❑	❑	❑	❑ $_____ ❑ _____ (salary)	EU _____ CL _____	❑ $____ Benefit Max	❑ $____ Benefit Max	❑ $_____	EU _____ CL _____
Spouse (SP)	❑	❑	❑				❑ Spouse coverage $_____	EU _____ CL _____				
Dependent Child(ren)	❑	❑	❑				❑ Child(ren)					
Family	❑	❑	❑	❑							❑	
I Decline	❑	❑	❑	❑	❑	❑	❑		❑	❑	❑	

***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**

Enrollee's Last Name ______ First Name ______ Subscriber Number ______ Group Number/Subgroup ______ / ______

SECTION C - ENROLLMENT EVENTS CONTINUED

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
❑ BCBSLA Individual Plan ❑ Medicare ❑ Medicaid ❑ VA Eligibility ❑ Other ______

Note: If waiving all coverages, please go to Section J, read and sign.

WAIVER OF DENTAL COVERAGE
❑ Waive
Note: If waiving all coverages, please go to Section J, read and sign.

ELSEWHERE CREDIT FOR DENTAL COVERAGE I decline to enroll for this coverage due to:
❑ Spouse's Group Employer Plan Plan Name ______ Policy Number ______
❑ BCBSLA Individual Plan ❑ Medicaid ❑ Tri-Care ❑ Parental Coverage (Employees under age 26)

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 ❑ Provisional Custody by Mandate ❑ Qualified Medical Child Support Order
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

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 Mo	Day	Yr	Social Security Number	Lives With You? If "No" Give Address/ Location**	Mentally Or Physically Incapacitated***	Out Of Area Dependent/ Student
E C			❑ Husband ❑ Wife					N/A	N/A	❑ YES ❑ NO
E C			❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other ______					❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C			❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other ______					❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C			❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other ______					❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C			❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other ______					❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C			❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other ______					❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ 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 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.? ❑ YES ❑ NO

Attach additional pages if necessary