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) _____
- ❑ Blue*Saver* (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

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

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 insurance? ❑ Yes ❑ No
BCBSLA or HMOLA? ❑ Yes ❑ No

Other Group? ❑ Yes ❑ No

If yes to either give: Policyholder | Insurance Company

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)
				❑ Medical ❑ Dental ❑ Limited Benefit
				❑ Medical ❑ Dental ❑ Limited Benefit
				❑ Medical ❑ Dental ❑ Limited Benefit
				❑ Medical ❑ Dental ❑ Limited Benefit
				❑ Medical ❑ Dental ❑ Limited Benefit

Are you or any of your dependents covered by Medicare?
❑ Yes ❑ 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
	❑ Over 65 ❑ Disabled ❑ End Stage Renal Disease	❑ Part A ❑ Part B ❑ Medicare Advantage ❑ Part D	A. ___/___/___ B. ___/___/___ C. ___/___/___ D. ___/___/___	A. _____ B. _____ C. _____ D. _____
	❑ Over 65 ❑ Disabled ❑ End Stage Renal Disease	❑ Part A ❑ Part B ❑ Medicare Advantage ❑ Part D	A. ___/___/___ B. ___/___/___ C. ___/___/___ D. ___/___/___	A. _____ B. _____ C. _____ D. _____

Are you or any of your Dependents currently receiving disability benefits?
❑ Yes ❑ No

If yes, complete the information on the right.

Name	Date of Injury/Illness	Reason for Disability
	/ /	
	/ /	
	/ /	

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

If yes, complete the information on the right.

Name	Date of Injury/Illness	Worker's Compensation Carrier Name
	/ /	
	/ /	
	/ /	

(Continue to next page)

Enrollee's Last Name _____ First Name _____ Subscriber 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! 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 all medical questions below. If "Yes" response to questions 1-5; provide details on page 5.
- 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 the following conditions or do the questions below apply:

1. Abnormal blood pressure?	❑ Yes	❑ No	14. Asthma, bronchitis, or chronic sinus trouble?	❑ Yes	❑ No
2. Any back and/or orthopedic condition or muscular diseases, back pain or joint pain?	❑ Yes	❑ No	15. Arthritis, rheumatism/bursitis or sciatica?	❑ Yes	❑ No
			16. Any tumors, cysts or growths?	❑ Yes	❑ No
3. Abdominal pain, ulcers, stomach, colon or other intestinal disorders, adhesions?	❑ Yes	❑ No	17. Kidneys stones or urinary system disorders, diabetes insipidus, or prostate disorders?	❑ Yes	❑ No
4. Alcohol or substance abuse, detoxification?	❑ Yes	❑ No	18. A mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation?	❑ Yes	❑ No
5. Are you presently taking medications?	❑ Yes	❑ No			
6. Diabetes mellitus?	❑ Yes	❑ No	19. Are you expecting a biological child within the next 9 months (male or female applicant)?	❑ Yes	❑ No
7. Any type of cancer?	❑ Yes	❑ No			
8. Any blood disorder?	❑ Yes	❑ No	20. Have you or anyone on this application, used tobacco in any form within the last 6 months including electronic cigarettes?	❑ Yes	❑ No
9. A stroke (CVA), circulatory problems or heart trouble?	❑ Yes	❑ No			
10. Epilepsy, seizures, fainting spells, or migraines?	❑ Yes	❑ No			
11. Lung problems or tuberculosis?	❑ Yes	❑ No	21. 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
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			

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

IF APPLYING FOR LIFE OR DISABILITY, PROVIDE DETAILS IF YOU ANSWERED "YES" TO QUESTIONS 1-5					
Question #	Person	Condition/Diagnosis	Treatment/Complications	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.? ❑ YES ❑ NO

Attach additional pages if necessary

Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email **MeaningfulAccessLanguageTranslation@bcbsla.com**. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

Section 1557 Coordinator
P. O. Box 98012
Baton Rouge, LA 70898-9012
225-298-7238 or 1-800-711-5519 (TTY 711)
Fax: 225-298-7240
Email: Section1557Coordinator@bcbsla.com

2. **If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan**.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.
إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ ຫ່ານຟຣີ. ຖ້າຫ່ານຕ້ອງການບໍລິການນັ້ນ,
ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທຫ້ ຢູ່ ທາງຫລັງຂອງບັດປະຈຳຕົວຂອງຫ່ານ.
ຖ້າຫ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود
کسٹمر سروس نمبر پر کال کریں۔ سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.