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

ADT

☐ EMPLOYEE ENROLLMENT ☑ EMPLOYEE CHANGE FORM

PLEASE PRINT AND COMPLETE IN BLACK INK ONLY **Group Number/Subgroup** 78E66ERC / ADT

2023 Open Enrollment - Medical Only

SECTION A - COVERAGE SELECTIONS

Blue Cross and Blue Shield of Louisiana
- ☑ GroupCare PPO (Plan) $1250 Deductible
- ☐ 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
			Select...			Choose one...	

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

Mailing Address	City	State	Zip Code	Fax Number	Annual Salary

Marital Status	Retired from Current Employer	Date Retired	Current Employer Name	Home Phone	Work Phone
☐ Married ☐ Single ☐ Other_____	☐ Yes ☐ No		Southern Medical Corporation		

* SECTION C - ENROLLMENT EVENTS

ENROLLMENT **Requested Effective Date** ___/01/2023 **Group #** 78E66ERC ☐ 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 78E66ERC /

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 (First M Last)	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 MM/DD/YY	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 78E66ERC /

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 78E66ERC /_____

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** 78E66ERC

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, BlueConnect, HMO and POS products. If you do not select a PCP, one will be selected for you.*

Enrollee Name	Social Security Number	Physician Name	Physician Address

*ASO/self-funded and non-standard large fully insured group employees: a PCP may be selected for you. Check with your group leader.

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, BlueConnect, HMO and POS products.*

*ASO/self-funded and non-standard large fully insured group employees: a PCP may be selected for you. Check with your group leader.

OFFICE USE ONLY			
	HEALTH EFFECTIVE DATE		UW INT. HLTH. DT.
	DENTAL	VISION	OUT OF ELIG.? ❑ YES ❑ NO

Attach additional pages if necessary