

**EMPLOYEE ENROLLMENT**     **EMPLOYEE CHANGE FORM**

PLEASE PRINT AND COMPLETE IN BLACK INK ONLY

Group Number/Subgroup \_\_\_\_\_ / \_\_\_\_\_

**\* ADT \***

**2022 Open Enrollment - Medical Only**

SECTION A - COVERAGE SELECTIONS	
<b>Blue Cross and Blue Shield of Louisiana</b> <input type="checkbox"/> GroupCare PPO (Plan) _____ <input type="checkbox"/> BlueSaver (Plan) _____ <input type="checkbox"/> Premier Blue (Plan) _____ <input type="checkbox"/> True Blue (Plan) _____	<b>HMO Louisiana, Inc.*</b> <input type="checkbox"/> HMO (Plan) _____ <input type="checkbox"/> Blue POS (Plan) _____ <input type="checkbox"/> Community Blue POS (Plan) _____ <input type="checkbox"/> BlueConnect POS (Plan) _____ <input type="checkbox"/> BlueConnect Acadiana _____

<input type="checkbox"/> Dental (Plan) _____ <input type="checkbox"/> Vision (Plan) _____	<b>Southern National Life Insurance Company, Inc.</b> <input type="checkbox"/> Group Term Life <input type="checkbox"/> Short Term Disability with Life <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
Physical Address		City	State	Zip Code	Telephone Number	E-mail Address	
Mailing Address		City	State	Zip Code	Fax Number	Annual Salary	
<b>Marital Status</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____	Retired from Current Employer <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Retired	Current Employer Name <i>Southern Medical Corporation</i>			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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____ (salary) <input type="checkbox"/> Spouse coverage \$ _____	EU _____ CL _____	<input type="checkbox"/> \$ _____ Benefit Max	<input type="checkbox"/> \$ _____ Benefit Max	<input type="checkbox"/> \$ _____	EU _____ CL _____
Spouse (SP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Child(ren)	EU _____ CL _____				
Dependent Child(ren)	<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"/>	
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"/>	<input type="checkbox"/>	

**\*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 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  Spouse's Group Employer Plan Plan Name \_\_\_\_\_ Policy Number \_\_\_\_\_  
**Note:** If waiving all coverages, please go to Section J, read and sign.  BCBSLA Individual Plan  Medicaid  Tri-Care  Parental Coverage (Employees under age 26)

**ELSEWHERE CREDIT FOR DENTAL COVERAGE** I decline to enroll for this coverage due to:

**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			<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

\*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 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      Other Group?  Yes  No      If yes to either give: \_\_\_\_\_      Policyholder \_\_\_\_\_      Insurance Company \_\_\_\_\_

BCBSLA or HMOLA?  Yes  No

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"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Limited Benefit
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Limited Benefit
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Limited Benefit
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Limited Benefit
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Limited Benefit

Are you or any of your dependents covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	Reason	Covered by:	Dates Medicare became effective	Medicare Numbers
If yes, complete the information on the right.		<input type="checkbox"/> Over 65	<input type="checkbox"/> Part A	A. ____ / ____ / ____	A. _____
		<input type="checkbox"/> Disabled	<input type="checkbox"/> Part B	B. ____ / ____ / ____	B. _____
Please provide a clear copy of the Medicare card.		<input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Medicare Advantage	C. ____ / ____ / ____	C. _____
			<input type="checkbox"/> Part D	D. ____ / ____ / ____	D. _____
		<input type="checkbox"/> Over 65	<input type="checkbox"/> Part A	A. ____ / ____ / ____	A. _____
		<input type="checkbox"/> Disabled	<input type="checkbox"/> Part B	B. ____ / ____ / ____	B. _____
		<input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Medicare Advantage	C. ____ / ____ / ____	C. _____
			<input type="checkbox"/> Part D	D. ____ / ____ / ____	D. _____
		<input type="checkbox"/> Over 65	<input type="checkbox"/> Part A	A. ____ / ____ / ____	A. _____
		<input type="checkbox"/> Disabled	<input type="checkbox"/> Part B	B. ____ / ____ / ____	B. _____

Are you or any of your Dependents currently receiving disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	Date of Injury/Illness	Reason for Disability
If yes, complete the information on the right.		____ / ____ / ____	
		____ / ____ / ____	
		____ / ____ / ____	

Are you or any of your Dependents currently receiving workers' comp benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	Date of Injury/Illness	Worker's Compensation Carrier Name
If yes, complete the information on the right.		____ / ____ / ____	
		____ / ____ / ____	
		____ / ____ / ____	

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

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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.? <input type="checkbox"/> YES <input type="checkbox"/> NO

*Attach additional pages if necessary*