



**BlueCross BlueShield
of Louisiana**

An independent licensee of the Blue Cross and Blue Shield Association.



A subsidiary of Blue Cross and Blue Shield of Louisiana,
independent licensees of the Blue Cross and Blue Shield Association.



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GROUP MEMBER ENROLLMENT GUIDE

GroupCare

BlueSaver

PremierBlue

*true
BLUE*

Important Information

Customer Service: 1-800-599-2583

Authorizations: 1-800-523-6435

Corporate Headquarters: 225-295-3307

Corporate Headquarters physical address:

5525 Reitz Avenue

Baton Rouge, LA 70809

Corporate Headquarters Mailing Address:

P.O. Box 98029

Baton Rouge, LA 70898-9029

Website: www.bcbsla.com

Hours of Operation:

Corporate Headquarters: 8:00 a.m. – 4:30 p.m., Monday - Friday

Customer Service: 8:00 a.m. – 5:30 p.m., Monday - Friday

Dear New Member:

Thank you for choosing Blue Cross and Blue Shield of Louisiana and/or our subsidiaries for your insurance needs. This Member Enrollment Guide is designed to handle all details necessary for you to become our newest member. Included is an instruction page, your enrollment form and important notices.

Your decision to enroll puts you in good company. Founded in 1934, Blue Cross and Blue Shield of Louisiana is the oldest domestic health insurer in Louisiana. We're a Louisiana-owned and -operated company, employing more than 1,400 residents and serving more than one million Louisianians.

Because of our longstanding relationship with hospitals, physicians and other health care providers in the state, we are able to offer special features and pass on the cost savings to our members. All of our participating providers agree to accept our negotiated payment amount and not bill members for charges in excess of the negotiated price, and they agree to file claims on behalf of our members. You can find a list of network providers at www.bcbsla.com.

After you complete the member enrollment process, you will receive your ID card and your certificate of coverage. Your ID card includes your member number, some benefit information and helpful phone numbers. Carry your ID card with you at all times for instant recognition from providers. Your certificate of health coverage gives a full explanation of your benefits.

As a member, your ID card is honored throughout Louisiana. You can travel with confidence knowing that if you need care, the Cross and Shield is recognized by health care providers throughout the United States and in more than 200 countries throughout the world.

We appreciate your business and look forward to providing you with prompt claims payment and exceptional customer service. Thank you for your confidence in our company, and thank you for **Choosing Blue**. All of us at Blue Cross and Blue Shield of Louisiana look forward to serving you today and for many years to come.

01MK1720 R02/07

Instructions for Enrollee/Change Form

Please read thoroughly before completing the enrollment application/change form. Be sure to complete the enrollee information on the top of each page. Any incomplete forms will be returned for completion.

Check either “Employee Enrollment” or “Employee Change Form.”

<p><i>Employers</i> <i>For all employees, including new hires, the top of pages 2 thru 4 must be completed in full.</i> <i><u>Enrollment and New Hires:</u> Enrollee’s ID Number with their social security number and Group Number/Subgroup must be identified</i> <i><u>Changes:</u> Enrollee’s ID Number with their employee’s member number and Group Number/Subgroup must be identified</i></p>	
<p>Section A Coverage Selections</p>	<ul style="list-style-type: none"> • Select medical, dental and life coverage options offered by your employer. • For medical coverage, indicate your deductible/coinsurance amounts or the medical plan number, where applicable. • Be sure to check “Yes” if your group is a Louisiana Association of Business and Industry (LABI) group. If you’re not sure, check with your group leader.
<p>Section B Enrollee Information</p>	<ul style="list-style-type: none"> • If you are a <u>new subscriber</u>, complete the entire section. • If you are an <u>established subscriber</u> making changes or adding a dependent, you only need to fill in your first and last name. • Hire date: if you are a rehire, note the date of your rehire in this section, not your original hire date. • Marital status: Other: Select this box if you are divorced or widowed.
<p>Section C Enrollment Events</p>	<ul style="list-style-type: none"> • Select “New” if this is your group’s initial enrollment with Blue Cross and/or HMO Louisiana or if you are a new hire serving eligibility. • Select “Late” if you are enrolling during open enrollment or if you are changing products. • Select “Rehire” if you are a rehire and be sure to indicate your new hire date in Section B. • Select “Special Enrollee” if you have experienced a qualifying event and indicate the event at the bottom of Section C. <ul style="list-style-type: none"> ◦ If you are unsure what your class is, check with your group leader. ◦ For health, dental and life, check the appropriate box for the product and coverage type in which you are enrolling. ◦ Select “I decline” for the product(s) in which you are not enrolling. ◦ Complete the “Waiver of Coverage” box if you are waiving coverage. ◦ For a change of status, mark the appropriate box under “Change” of Section C. Indicate your qualifying event, if applicable, and be sure to give the day, month and year of the event.

<p style="text-align: center;">Section D Employer Information</p>	<p><i>To Be Completed By Employer</i></p> <ul style="list-style-type: none"> Group Leaders must complete this section if an employee is MAKING A CHANGE or if the EMPLOYEE is CANCELING coverage. The group leader's signature is required for any changes indicated in this section. Product Selection Change: If your group offers more than one medical plan and an employee is changing plans during open enrollment. You may need to also change the class of the employee. Subgroup Change: If your group has billing set up for multiple locations or divisions and an employee is changing locations, the employee will be changing subgroups. Based on your billing subgroup number, indicate the subgroup they are moving from and the subgroup they are moving to. You may need to also change the class of the employee. Cancellation of Coverage: Provide the reason the employee is canceling coverage and the last date of employment. Class Change: Changes may result in a change to the employee's classification. Indicate the new class. A terminating employee will need COBRA or State Continuation class change indicated.
<p style="text-align: center;">Section E Family Members</p>	<ul style="list-style-type: none"> In the first column, indicate the family members who are enrolling (E), changing (C) or deleting (D). Complete each applicable section in full. An out-of-area dependent is a dependent who lives out-of-state.
<p style="text-align: center;">Section F Life Insurance Information</p>	<ul style="list-style-type: none"> If you are splitting your life insurance among beneficiaries, you must indicate the percentage that should go to each beneficiary. If you do not indicate a beneficiary, the beneficiary will automatically be designated as the "estate of."
<p style="text-align: center;">Section G Other Coverage Information</p>	<p>Complete this section only if you or your dependents have other coverage.</p> <ul style="list-style-type: none"> Please give the complete names of your dependents. We cannot accept "mother," "daughter," etc. Type of Coverage: Comprehensive coverage includes a full-coverage employer sponsored or individually owned health insurance plan. Limited Benefit coverage includes an employer sponsored or individually owned policy which is specific in the type of coverage provided. For example dental, vision, cancer, specific disease, hospital indemnity or a limited coverage group medical policy.
<p style="text-align: center;">Section H Medical History</p>	<ul style="list-style-type: none"> Complete this section if required by your group. Provide an explanation of medical conditions you checked using the Medical Questionnaire Guide. If the guide is not available, provide details in the second table listed.
<p style="text-align: center;">Section I Coverage Conditions</p>	<ul style="list-style-type: none"> Please carefully read this section and sign and date.

EMPLOYEE ENROLLMENT **EMPLOYEE CHANGE FORM**
PLEASE PRINT AND COMPLETE IN BLACK INK ONLY

SECTION A - COVERAGE SELECTIONS

Blue Cross and Blue Shield of Louisiana

PPO (Ded/Coins.) _____

TrueBlue (Ded/Coins.) _____

BlueSaver (Ded/Coins.) _____

Premier Blue (Plan #) _____

Dental

HMO Louisiana, Inc.

HMO (Plan #) _____

POS (Plan #) _____

Southern National Life Insurance Company, Inc.

Life/AD&D

Dependent Life

Short Term Disability

SECTION B - EMPLOYEE INFORMATION

ENROLLEE'S LAST NAME FIRST MI SEX (M/F) BIRTHDATE (MM/DD/YYYY) HIRE DATE OCCUPATION SOCIAL SECURITY NUMBER

MAILING ADDRESS CITY STATE ZIP E-MAIL ADDRESS HOME PHONE WORK PHONE

MARITAL STATUS MARRIED SINGLE OTHER (explain below) RETIRED YES NO DATE RETIRED EMPLOYER NAME

SECTION C - ENROLLMENT EVENTS

ENROLLMENT

New Late Rehire Special Enrollee (Go to Qualifying Event Section Below.)

Class (Select One): Active Management Non-Management Retiree COBRA/State Continuation* Other

*Please complete form 23XX0500 for BCBSLA products and form 03100 00081 for HMO products.

I am enrolling for:

Health: Employee Only Employee & Spouse Employee & Dependent Child(ren) Employee and Family I Decline

Dental: Employee Only Employee & Spouse Employee & Dependent Child(ren) Employee and Family I Decline

Life: Employee Only Employee & Spouse Employee & Dependent Child(ren) Employee and Family I Decline

CHANGING (Please complete Section E) Requested Effective Date ____ / ____ / ____

Type of Change: Name Address Add Dependent Delete Dependent Subgroup Class Cancellation Qualifying Event (Complete next section)

QUALIFYING EVENT

Marriage Birth Adoption Placement for Adoption Date of Qualifying Event Date ____ / ____ / ____

Divorce Death Termination or reduction in work hours Employee contributions for coverage ended Other (Refer to instruction page)

If you lost other coverage, was it due to: Divorce Death Termination or reduction in work hours Employee contributions for coverage ended Other (Refer to instruction page)

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, or if the employee is canceling coverage.

Employer Name _____ Employer Signature _____ Date ____ / ____ / ____ Group/Subgroup Number ____ / ____

Product Selection Change (please refer to instruction page) _____ Subgroup Change: Move From ____ / ____ Move To ____

Cancellation of Coverage: Cancel Coverage (reason) _____ Last Date of Employment ____ / ____ / ____

Class Change To: Active Management Non-Management COBRA/State Continuation* Retiree Other (Explain) _____

*Note: If choosing COBRA or Louisiana State Continuation, please complete form 23XX0500 for BCBSLA products or 03100 00081 for HMO products.

SECTION E - FAMILY MEMBERS TO BE ENROLLED, CHANGED OR DELETED

ENROLL, CHANGE OR DELETE (Please circle the appropriate answer)	DEPENDENT'S FULL NAME (LAST, FIRST, MI)	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 D	SPOUSE	<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE			N/A	N/A	<input type="checkbox"/> YES <input type="checkbox"/> NO
E C D		<input type="checkbox"/> SON <input type="checkbox"/> STEFSON <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 D		<input type="checkbox"/> SON <input type="checkbox"/> STEFSON <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 D		<input type="checkbox"/> SON <input type="checkbox"/> STEFSON <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 D		<input type="checkbox"/> SON <input type="checkbox"/> STEFSON <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 D		<input type="checkbox"/> SON <input type="checkbox"/> STEFSON <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 • Additional information needed

SECTION F - LIFE INSURANCE INFORMATION

Job Title: _____ Salary: _____ Monthly Annually

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 _____ %

SECONDARY LIFE BENEFICIARIES: Contingent on the above-named beneficiaries' death, please designate the following as my 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 _____ %

SECTION G - OTHER COVERAGE INFORMATION

Do you or any dependents have other health insurance? Yes No Other Group? Yes No If yes to either give: _____ Policyholder _____ Insurance Company _____

COMPLETE FOR EACH PERSON AGE 19 AND OLDER
 Has anyone on this application been covered with health benefits, including coverage with Blue Cross and Blue Shield of Louisiana, 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. _____

Enrollee's Last Name _____	Enrollee's First Name _____	Enrollee's ID Number _____	Group Number/Subgroup _____ / _____
Are you or any of your dependents currently receiving disability/Workers' Comp Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the information on the right.		Date Coverage Began	Date Coverage Began
Name		Name	Name
		/ /	/ /
		/ /	/ /
		/ /	/ /

SECTION H - MEDICAL HISTORY
 Any personal health information (PH) obtained by Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana Inc. (HMOLA), and/or Southern National Life Insurance Company, Inc. (SNL) in connection with the enrollment form may be retained by BCBSLA, HMOLA and/or SNL 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 4

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. Other 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 a 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. Any back/orthopedic condition or muscular diseases? Yes No
 20. Tumors or cysts? 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
 28. Female reproductive problems? 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

- 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
 43. Have you, or anyone on this application, ever had any health insurance postponed, rated, ridered, 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, dentists/oral surgeons, etc.) in the last 5 years? Yes No

