



**EMPLOYEE ENROLLMENT FORM FOR GROUP COVERAGE**

**COMPLETE IN BLACK INK ONLY**

- PPO/Traditional
- Blue Saver
- True Blue
- NEW
- LATE
- REHIRE

01	02	03	04
CONTRACT NO.		HEALTH OED	GROUP NO.
WC	CL	BASIC	SUPP.
UW INT. HLTH-DT.	DENT. TY/CL	DENT. WC	CONV. DATE
CLK CODE	LIFE OED	LIFE CLASS	LIFE COV.
BASIC STD.	BASIC DEP.		
MEDICALLY UNDERWRITE	<input type="checkbox"/> BASIC LIFE	<input type="checkbox"/> SUPP. LIFE	<input type="checkbox"/> HEALTH
LIFE CODE	OUT OF ELIG.?	BASIC ELIG. AMT.	BASIC GI AMT.
<input type="checkbox"/> YES	<input type="checkbox"/> NO	SUPP. ELIG. AMT.	SUPP. GI AMT.

**PLEASE COMPLETE THIS SECTION**

SOCIAL SECURITY NO.	ENROLLEE'S LAST NAME (Print)		FIRST (Print)	MI	AC	PHONE															
MAILING ADDRESS		APT.#	CITY	ST.	ZIP	DATE OF BIRTH															
						<input type="checkbox"/> MALE															
						<input type="checkbox"/> FEMALE															
NAME OF EMPLOYER		GROUP NO./DEPT. NO.	DATE EMPLOYED	OCCUPATION	SALARY \$	<input type="checkbox"/> HOURLY															
						<input type="checkbox"/> MONTHLY															
						<input type="checkbox"/> ANNUAL															
DO YOU HAVE	PART A MEDICARE?	<input type="checkbox"/> YES	YOUR PART A MEDICARE NO.	YOUR PART A EFFECTIVE DATE	MO.	DAY	YR.	RETIRED	DATE	MO.	DAY	YR.	BADGE NO.								
		<input type="checkbox"/> NO						<input type="checkbox"/> YES	<input type="checkbox"/> NO												
DO YOU HAVE	PART B MEDICARE?	<input type="checkbox"/> YES	YOUR PART B MEDICARE NO.	YOUR PART B EFFECTIVE DATE	MO.	DAY	YR.	REASON FOR MEDICARE ENTITLEMENT (CHECK ALL THAT APPLY)													
		<input type="checkbox"/> NO						<input type="checkbox"/> AGE	<input type="checkbox"/> DISABILITY	<input type="checkbox"/> ESRD	<input type="checkbox"/> DISABILITY & ESRD										
DO YOU OR ANY DEPENDENTS HAVE OTHER HEALTH INSURANCE?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	BLUE CROSS AND BLUE SHIELD?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	OTHER GROUP?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES TO EITHER GIVE:	POLICYHOLDER	INSURANCE COMPANY	ARE YOU OR ANY OF YOUR DEPENDENTS CURRENTLY RECEIVING DISABILITY/ WORKERS' COMP. BENEFITS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DENTAL COVERAGE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DENTAL CLASS	<input type="checkbox"/> FAMILY	<input type="checkbox"/> SINGLE

**HAVE YOU OR ANY DEPENDENT(S) BEING ADDED HAD OTHER HEALTH COVERAGE WITHIN 63 DAYS?  YES  NO IF YES, PLEASE COMPLETE THE PRIOR CARRIER HEALTH COVERAGE FORM - 23XX1938.**

**PLEASE COMPLETE THIS SECTION ONLY IF DEPENDENTS ARE TO BE COVERED**

DO ANY OTHER DEPENDENTS HAVE	PART A MEDICARE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PART B MEDICARE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PART A MEDICARE NO.	PART B MEDICARE NO.	PART A EFFECTIVE DATE	MO.	DAY	YR.	PART B EFFECTIVE DATE	MO.	DAY	YR.	REASON FOR MEDICARE ENTITLEMENT				
																	<input type="checkbox"/> AGE				
																	<input type="checkbox"/> DISABILITY				
																	<input type="checkbox"/> ESRD				
																	<input type="checkbox"/> DISABILITY & ESRD				
DEPENDENT'S FULL NAME (Include First, Last, MI)	SOCIAL SECURITY NUMBER		DATE OF BIRTH		CHECK RELATIONSHIP. IF DEPENDENT IS OVER 20, INDICATE IF FULL-TIME STUDENT. IF DEPENDENT IS NOT NATURAL CHILD, ATTACH CERTIFIED DOCUMENTATION OF LEGAL CUSTODY OR ADOPTION.																
SPOUSE			MO.	DAY	YR.	<input type="checkbox"/> HUSBAND	<input type="checkbox"/> WIFE	FULL-TIME STUDENT	DEPENDS UPON YOU FOR SUPPORT?	DATE DEPENDENCY BEGAN	RESIDES WITH YOU?										
OLDEST CHILD						<input type="checkbox"/> SON	<input type="checkbox"/> STEPSON	<input type="checkbox"/> DAUGHTER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO					
						<input type="checkbox"/> SON	<input type="checkbox"/> STEPSON	<input type="checkbox"/> DAUGHTER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO					
						<input type="checkbox"/> SON	<input type="checkbox"/> STEPSON	<input type="checkbox"/> DAUGHTER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO					
						<input type="checkbox"/> SON	<input type="checkbox"/> STEPSON	<input type="checkbox"/> DAUGHTER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO					

**FOR BLUE SAVER ONLY - OPTION: OPEN A HEALTH SAVINGS ACCOUNT**

I intend to open a Health Savings Account.  Yes  No Please open an account with [my Blue Saver H.S.A.]  Yes  No

**OFFICE USE ONLY**

- I, the undersigned, do hereby enroll for membership in Louisiana Health Service & Indemnity Company (LHSIC), for myself and family members, if any, listed on this enrollment form. I understand that this enrollment form, any Change of Status Card and contract, together with any riders and endorsements issued by LHSIC, constitute my only agreement with LHSIC. If the enrollment form is accepted, a certificate will be issued. 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 the Member(s)'s coverage and all fees, less claims paid, will be refunded if a material misrepresentation of fact as to that Member(s) exists in the enrollment form or any Change of Status Card.
- I authorize any employer having information available as to employment, or other insurance coverage, regarding me or other family members proposed for health coverage, to give the information to LHSIC or any agent acting on LHSIC's behalf. I understand this information will be used by LHSIC 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, authorize deduction from my pay the amounts, if any, as may be necessary. The information given herein is true and correct to the best of my knowledge and belief.
- 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."

**IT IS A DEPENDENT'S RESPONSIBILITY TO APPLY FOR CONTINUOUS COVERAGE ON A SEPARATE CONTRACT/CERTIFICATE WHEN ELIGIBILITY CEASES.**

Any personal health information (PHI) obtained by Blue Cross and Blue Shield of Louisiana in connection with the enrollment form may be retained by Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc., and used or disclosed in connection with future underwriting/renewal efforts.

**IMPORTANT! PLEASE ANSWER ALL QUESTIONS BELOW FOR ALL APPLICANTS. FOR EACH POSITIVE RESPONSE, UNDERLINE THE APPROPRIATE STATEMENT OR CONDITION AND COMPLETE THE MEDICAL QUESTIONNAIRE ON PAGE 3.**

Your Height: \_\_\_\_\_ Your Weight: \_\_\_\_\_ Spouse's Height: \_\_\_\_\_ Spouse's Weight: \_\_\_\_\_

**HAS ANYONE APPLYING FOR COVERAGE EVER HAD:**

- 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. Been diagnosed with Rheumatic Fever? . . . . .  Yes  No
- 8. Been diagnosed with abnormal blood pressure? . . . . .  Yes  No
- 9. Heart Trouble? . . . . .  Yes  No
- 10. Been diagnosed with Tuberculosis? . . . . .  Yes  No
- 11. Had or have other lung problems? . . . . .  Yes  No
- 12. Tested positively for HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC? . . . . .  Yes  No
- 13. Been diagnosed with either Hepatitis or a liver disorder? . . . . .  Yes  No

**HAS ANYONE APPLYING FOR COVERAGE HAD IN THE LAST 5 YEARS:**

- 14. Been diagnosed with asthma, bronchitis or chronic sinus trouble? . . . . .  Yes  No
- 15. Been diagnosed with allergies? . . . . .  Yes  No
- 16. Been treated for arthritis? . . . . .  Yes  No
- 17. Been treated for Rheumatism/Bursitis or Sciatica? . . . . .  Yes  No
- 18. Had any bodily deformities? . . . . .  Yes  No
- 19. Had any back/orthopedic condition or muscular diseases? . . . . .  Yes  No
- 20. Had any known tumors or cysts? . . . . .  Yes  No
- 21. Been treated for kidney stones or urinary system disorders, diabetes insipidus or prostate disorders? . . . . .  Yes  No
- 22. Been diagnosed with an endocrine disorder thyroid problem or goiter? . . . . .  Yes  No
- 23. Been treated for hemorrhoids/rectal ailments or varicose veins? . . . . .  Yes  No
- 24. Had a hernia? . . . . .  Yes  No
- 25. Had seizures, fainting spells? . . . . .  Yes  No
- 26. Had headaches? . . . . .  Yes  No
- 27. Had irregular/excessive menstrual bleeding? . . . . .  Yes  No
- 28. Had any other female reproductive problems? . . . . .  Yes  No
- 29. Had pelvic pain? . . . . .  Yes  No
- 30. Had gall stones or gall bladder disorder? . . . . .  Yes  No
- 31. Had abdominal pain? . . . . .  Yes  No
- 32. Had ulcers, stomach, colon or other intestinal disorders, adhesions? . . . . .  Yes  No
- 33. Had any eye conditions (excluding corrective lenses)? . . . . .  Yes  No
- 34. Had any ear condition or impairment? . . . . .  Yes  No
- 35. Had a mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation? . . . . .  Yes  No
- 36. Had candidiasis (yeast infection), herpes, syphilis, gonorrhea, condylomata acuminata (genital warts), or other sexually transmitted diseases? . . . . .  Yes  No
- 37. Suffered from or received treatment for alcohol or substance abuse, detoxification? . . . . .  Yes  No
- 38. Had 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 for conditions not mentioned in other questions? . . . . .  Yes  No
- 42. Are you, or anyone on this application, engaged in private flying, parachuting, hang gliding, racing, underwater diving, handling of explosive materials, hazardous wastes or materials? . . . . .  Yes  No
- 43. Have you, or anyone on this application, ever had any health insurance postponed, rated, ridered, declined, canceled, or had reinstatement refused? . . . . .  Yes  No
- 44. Any departure from good health or any medical or surgical advice or treatment from any medical practitioner (medical doctor/surgeon, podiatrist, optometrist, chiropractor, dentists/oral surgeons, etc.) in the last 5 years? . . . . .  Yes  No

**PROVIDE DETAILS ACCORDING TO THE MEDICAL QUESTIONNAIRE GUIDE**

Question Number: _____ Person: _____ Condition: _____ Comments:	a. b. c. d. e. f. g.
Question Number: _____ Person: _____ Condition: _____ Comments:	a. b. c. d. e. f. g.
Question Number: _____ Person: _____ Condition: _____ Comments:	a. b. c. d. e. f. g.
Question Number: _____ Person: _____ Condition: _____ Comments:	a. b. c. d. e. f. g.

**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.

All of the questions in the health history section have been read by or to me and the answers given are provided by the applicant and/or dependent(s) if any.

**X** \_\_\_\_\_  
 Enrollee's Signature

\_\_\_\_\_  
 Date

**WAIVER OF ENROLLMENT**

I have been given the opportunity to enroll for group health coverage offered to me through my employer. I have decided not to take advantage of the offer for:

HEALTH

DENTAL

Reason I am declining this coverage: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
NAME OF GROUP

\_\_\_\_\_  
GROUP NUMBER

X

\_\_\_\_\_  
SIGNATURE OF EMPLOYEE  
(Do not sign if enrolling for coverage)

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

X

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE



## YOUR RIGHTS REGARDING THE RELEASE OF GENETIC INFORMATION

**Blue Cross and Blue Shield of Louisiana**, shall not, solely on the basis of any genetic information concerning an individual or family member or solely on the basis of an individual's or family member's request for or receipt of genetic services, or refusal to submit to a genetic test or make available the results of a genetic test:

- (1) Terminate, restrict, limit or apply conditions to the coverage provided under the policy or plan, or restrict the sale of the policy or plan to an individual or family member;
- (2) Cancel or refuse to renew the coverage of an individual or family member under the policy or plan;
- (3) Deny coverage or exclude an individual or family member from coverage under the policy or plan;
- (4) Impose a rider that excludes coverage for certain benefits or services under the policy or plan;
- (5) Establish differentials in premium rates or cost-sharing for coverage under the policy or plan; or
- (6) Otherwise discriminate against an individual or family members in the provision of insurance.

**Blue Cross and Blue Shield of Louisiana** is prohibited by law from requiring any applicant or subscriber to undergo genetic testing or to be subjected to questions relating to genetic information.

As provided by law, "genetic information" means all information about genes, gene products, inherited characteristics, or family history/pedigree as expressed in common language.