

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	DEPENDS ON YOU FOR SUPPORT. IF YES, DATE DEPENDENCY BEGAN	FULL-TIME STUDENT*	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	N/A	N/A	<input type="checkbox"/> YES <input type="checkbox"/> NO
E C D		<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	<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"/> 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	<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"/> 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	<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"/> 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

*If your dependent is a full-time student, please provide the following: Name of School: _____ School Address: _____

Original Enrollment Date: _____ Expected Date of Graduation: _____ Current Term: From _____ To _____

**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 _____

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	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
					<input type="checkbox"/> Comprehensive <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"/> 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	Name	Date Coverage Began	Name	Date Coverage Began
		/ /		/ /
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. (SNL) in connection with the enrollment form may be retained by BCBSLA, HMOLA and/or SNL, Inc. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Abnormal blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Any type of cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Heart trouble?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Any blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. A stroke (CVA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Other lung problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Circulatory problems?	<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
6. Epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Hepatitis or a liver disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Rheumatic fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

IN THE LAST 5 YEARS HAS ANYONE APPLYING FOR COVERAGE HAD OR BEEN DIAGNOSED WITH:

14. Asthma, bronchitis or chronic sinus trouble?	<input type="checkbox"/> Yes <input type="checkbox"/> No	28. Female reproductive problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	29. Pelvic pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Arthritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	30. Gall stones or gall bladder disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Rheumatism/Bursitis or Sciatica?	<input type="checkbox"/> Yes <input type="checkbox"/> No	31. Abdominal pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Had any bodily deformities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	32. Ulcers, stomach, colon or other intestinal disorders, adhesions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Any back/orthopedic condition or muscular diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No	33. Any eye conditions (excluding corrective lenses)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Tumors or cysts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	34. Any ear condition or impairment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Kidney stones or urinary system disorders, diabetes insipidus or prostate disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	35. A mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Endocrine disorder thyroid problem or goiter?	<input type="checkbox"/> Yes <input type="checkbox"/> No	36. Candidiasis (yeast infection), herpes, syphilis, gonorrhea, condylomata acuminata (genital warts), or other sexually transmitted diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Hemorrhoids/rectal ailments or varicose veins?	<input type="checkbox"/> Yes <input type="checkbox"/> No	37. Alcohol or substance abuse, detoxification?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. A hernia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	38. Any condition (including developmental defects or deformities) of oral cavity, jaw, facial or cranial bones, teeth and surrounding structures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Seizures, Fainting Spells?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
26. Headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
27. Irregular/excessive menstrual bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

MISCELLANEOUS:

39. Are you expecting a biological child within the next 9 months (male or female applicant)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	43. Have you, or anyone on this application, ever had any health insurance postponed, rated, rideder, declined, cancelled, or had reinstatement refused?	<input type="checkbox"/> Yes <input type="checkbox"/> No
40. Have you, or anyone on this application, used tobacco in any form within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
41. Are you presently taking medications?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

