MEMBER ENROLLMENT GUIDE

BlueSaver

GroupCare

PremierBlue

true BLUE

BLUE CHIP

 Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company

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."

	Employers *For all employees, including new hires, the top of pages 2 thru 4 must be completed in full.* *Enrollment and New Hires: Enrollee's ID Number with their social security number and Group Number/Subgroup must be identified* *Changes: Enrollee's ID Number with their employee's member number and Group Number/Subgroup must be identified*
Section A Coverage Selections	• **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.
Section B Enrollee Information	• **If you are a new subscriber, complete the entire section**. • If you are an **established subscriber 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.

Section C Enrollment Events	• **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.
	  ◦ 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.

Section	Instructions
Section D Employer Information	***To Be Completed By Employer*** • 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.
Section E Family Members	• 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.
Section F Life Insurance Information	• 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.**"
Section G Other Coverage Information	**Complete this section only if you or your dependents have other coverage.** • 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.
Section H Medical History	• 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.
Section I Coverage Conditions	• Please carefully read this section and sign and date.

BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.

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

Southern National Life Insurance Company, Inc.
A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

❑ 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.) ______ ❑ Dental
❑ Premier Blue (Plan #) ______ ❑ BlueSaver (Ded/Coins.) ______

HMO Louisiana, Inc.
❑ HMO (Plan #)
❑ POS (Plan #) ______

Southern National Life Insurance Company, Inc.
❑ Life ❑ Dependent Life

LABI ❑ Yes ❑ No

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 **Requested Effective Date** ____/____/____
❑ 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

WAIVER OF COVERAGE
I decline to enroll for this coverage due to:
❑ Spouse's Employer Plan
❑ Individual Plan ❑ Medicare
❑ COBRA from Prior Employer
❑ VA Eligibility ❑ Medicaid ❑ Tri-Care
❑ Other ______
If waiving all coverages, please go to Section I, read and sign.

CHANGE (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** ____/____/____

If you lost other coverage, was it due to: ❑ Divorce ❑ Death ❑ Termination or reduction in work hours ❑ Employer contributions for coverage ended ❑ COBRA coverage exhausted ❑ 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 HMOLA products.

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 ______ Enrollee's First Name ______ Enrollee's ID Number ______ Group Number/Subgroup ____/____

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	❑ HUSBAND ❑ WIFE			N/A	N/A	N/A	N/A	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ______			❑ YES ❑ NO / /	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ______			❑ YES ❑ NO / /	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ______			❑ YES ❑ NO / /	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ______			❑ YES ❑ NO / /	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ 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 Blue Cross and Blue Shield? ❑ 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? ❑ 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)
					❑ Comprehensive ❑ Limited Benefit
					❑ Comprehensive ❑ Limited Benefit
					❑ Comprehensive ❑ Limited Benefit
					❑ Comprehensive ❑ Limited Benefit
					❑ Comprehensive ❑ 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
		❑ 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. ______

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? ❑ Yes ❑ No If yes, complete the information on the right.	Name	Date Coverage Began	Name	Date Coverage Began
		/ /		/ /
		/ /		/ /
		/ /		/ /

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:

Question			Question		
1. Diabetes mellitus?	❑ Yes	❑ No	8. Abnormal blood pressure?	❑ Yes	❑ No
2. Any type of cancer?	❑ Yes	❑ No	9. Heart trouble?	❑ Yes	❑ No
3. Any blood disorder?	❑ Yes	❑ No	10. Tuberculosis?	❑ Yes	❑ No
4. A stroke (CVA)?	❑ Yes	❑ No	11. Other lung problems?	❑ Yes	❑ No
5. Circulatory problems?	❑ Yes	❑ No	12. HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC?	❑ Yes	❑ No
6. Epilepsy?	❑ Yes	❑ No			
7. Rheumatic fever?	❑ 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:

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

MISCELLANEOUS:

Question			Question		
39. Are you expecting a biological child within the next 9 months (male or female applicant)?	❑ 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
40. Have you, or anyone on this application, used tobacco in any form within the last 12 months?	❑ 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
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			

Enrollee's Last Name ______ Enrollee's First Name ______ Enrollee's Number ______ Group Number/Subgroup ____ / ____

PROVIDE DETAILS ACCORDING TO THE MEDICAL QUESTIONNAIRE GUIDE - ATTACH ADDITIONAL PAGES IF NECESSARY

Question #	Person	Condition/Diagnosis	A	B	C	D	E	F	G

IF MEDICAL QUESTIONNAIRE IS UNAVAILABLE, PROVIDE DETAILS FOR EACH "YES" RESPONSE IN THE FORMAT BELOW. ATTACH ADDITIONAL PAGES IF NECESSARY

Question #	Person	Condition/Diagnosis	Treatment/Complications	Physician's Name	Dates Treated	Medications, Frequency, Dosage

SECTION I - COVERAGE CONDITIONS

1. I, the undersigned, do hereby enroll for membership in Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana, Inc. (HMOLA) and/or Southern National Life Insurance Company, Inc. (SNL) for myself and family members, if any, listed on this enrollment form. I understand that this enrollment/change form and contract, together with any riders and endorsements issued by BCBSLA, constitute my only agreement with BCBSLA, HMOLA and/or SNL. 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 coverage and all fees, less claims paid, will be refunded if a material misrepresentation of fact as to my dependents and me exists in the enrollment/change form.
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 BCBSLA, HMOLA and/or SNL or any agent acting on BCBSLA, HMOLA and/or SNL's behalf. I understand this information will be used by BCBSLA, HMOLA. and/or SNL 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 herein 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 my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after coverage ends. 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 the health history section have been read by or to me and the answers given are provided by the enrollee and/or dependent(s) if any.

X ______________________ Date ______________________

Enrollee's Signature **Enrollee's Signature Date**

OFFICE USE ONLY

01 ______ 02 ______ 03 ______ 04 ______

SUBSCRIBER ID NUMBER	GROUP NO.	SUBGROUP	CL	PRODUCT ID	HEALTH OED	WC	UW INT. HLTH. DT.	DENT. TY/CL	DENT. WC	LIFE OED	LIFE CL

LIFE COV.	BASIC	SUPP	**MEDICALLY UNDERWRITE:**	❑ BASIC LIFE	❑ SUPP. LIFE	❑ HEALTH	LIFE CODE	OUT OF ELIG.? ❑ YES ❑ NO	BASIC ELIG AMT.	BASIC GI AMT.	SUPP. ELIG. AMT.	SUPP. GI. AMT.

Attach additional pages if necessary

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.

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT ENROLLMENT NOTICE FOR ALL COVERED MEMBERS

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, coinsurance, and co-payments (if any) applicable to other medical and surgical benefits provided under this plan. Information on the plan's specific deductible, coinsurance, or co-payment amounts is found in the Schedule of Benefits document that is issued with your health benefit booklet.

If you have questions about this notice or about the coverage described herein, please contact our Customer Service Department at 1-800-599-2583.

40XX0941 R04/05

BlueCross BlueShield of Louisiana

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

HMO Louisiana, Inc.

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

SUMMARY OF PRIVACY PRACTICES NOTICE

Blue Cross and Blue Shield of Louisiana and its affiliate, HMO Louisiana, Inc., believe that privacy and confidentiality regarding personal medical information is important to every customer. And securely protecting our customers' privacy is a responsibility we take very seriously.

We want you to know there is now a federal regulation that governs the privacy of your medical information and how we use and share that information in the course of our regular business activities. This federal regulation requires us to provide you with a detailed description – or "Notice" – of how we use your medical information.

The attached Notice goes into detail on how we may use and share your medical information in the course of treatment, payment and health care (business) operations. In general, unless it is described in the accompanying Notice, we will **not** use or disclose your medical information **without** your written authorization. For example, we may use and disclose your medical information to:

- Enroll you in our plan
- Determine your eligibility for benefits
- Pay your claims
- Underwrite your contract / certificate of coverage
- Audit our business practices
- Conduct medical reviews
- Conduct quality improvement activities
- Bill you or your employer for your premiums
- Develop strategic business plans

Your information may be shared with the physicians or other providers who treat you, with other insurance companies, with your employer (following specific guidelines), or with a company we hire to help us do our work. We may also disclose your medical information to your family members, friends and others you choose to involve in your health care or in the payment of your health care.

Although this occurs rarely, we may also use and disclose your medical information when required by law for various public interest activities, including regulatory oversight of our company (by the Department of Insurance, for example), law enforcement, disaster relief, and certain other public benefit functions.

The federal privacy rules also give you certain rights. Please review this entire Notice to learn about your rights and how to put them to use for you, as well as the procedure to voice complaints regarding our privacy practices.

Maintaining your trust and confidence is our highest priority, and we value your business. Thank you for being our customer.

01MK1780 2/03 Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company

BLUE CROSS AND BLUE SHIELD OF LOUISIANA & HMO LOUISIANA, INC.
NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and send the new Notice to our health plan subscribers at the time of the change.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this Notice.

Uses and Disclosures of Medical Information

We will refer to your "health information" throughout this Notice. When we say "Health Information," we mean what the federal privacy rules ("the HIPAA privacy regulations") call "Protected Health Information." This is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; (iii) the past, present, or future payment for the provision of health care to you. Any terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Regulations as set out in 45 C.F.R. § 164.501.

REQUIRED DISCLOSURES OF YOUR HEALTH INFORMATION

We **must** disclose your health information:

- To you or someone who has the legal right to act for you (your personal representative), if the information you seek is contained in a designated record set, and
- The Secretary of the Department of Health and Human Services, if necessary, to investigate or determine our compliance with the HIPAA Privacy Regulations.

PERMISSIVE DISCLOSURES OF YOUR HEALTH INFORMATION

We **have the right** to use and disclose your health information for:

Treatment: We may disclose your health information to a physician or other health care provider to treat you. For example, we may send a copy of a member's medical records we maintain to a physician who needs the additional information to treat the member.

Payment: We may use and disclose your health information to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits, and the like. We may disclose your health information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your health information for health care operations. Health care operations include:

- reviewing and evaluating health care provider and health plan performance, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- health care quality assessment and improvement activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage; and
- business planning, development, management, and general administration, including customer service, grievance resolution, de-identifying health information, and creating limited data sets for health care operations, public health activities, and research.

For a full list of the activities covered by the terms in this section please consult the definitions set out in 45 C.F.R. § 164.501.

Others Covered by the Privacy Rule: We may disclose your health information to another health plan or to a health care provider for certain health care operations subject to federal privacy protection laws. We may do so as long as the plan or provider has or had a relationship with you and the health information is for that plan's or provider's health care quality assessment and improvement activities, evaluation, or fraud and abuse detection and prevention.
For example, we may share your information with your doctors for their licensing or credentialing activities.

Business Associates: We hire individuals and companies to perform various functions on our behalf or to provide certain types of services for us. In order to help us, these business associates may receive, create, maintain, use, or disclose your health information. Before they may have any contact with your health information, we require them to sign a written agreement stating they will keep your health information private and secure.

Examples of our business associates include:

- Medical experts hired to review claims
- A pharmacy benefits management company hired to assist us in managing pharmacy claims.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. However, we will not be able to undo any action that was taken before that authorization was revoked. Unless you give us a written authorization, we will not use or disclose your health information for any purpose other than those described in this Notice.

Family, Friends, and Others Involved in Your Care or Payment for Care: Unless you object, we may disclose your health information to a family member, friend or any other person you involve in your health care or payment for your health care. We will disclose only the health information that is related to the person's involvement.
We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in appropriate situations, such as medical emergency or during disaster relief efforts. (For example, to Red Cross during a natural disaster.)
Before we make such a disclosure, we will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing your health information is in your best interest under the circumstances.

Your Employer: We may disclose to your employer whether or not you are enrolled in a health plan that your employer sponsors. We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan. Summary health information is information about claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although this summary health information does not specifically identify any individual, it still may be possible to identify you or others through review of this summary health information.
We may disclose your health information and the health information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must meet certain requirements. This includes amending the plan document for your group health plan to establish the limited uses and disclosures it may make of your health information. Please see your group health plan document for a full explanation of the limitations placed on your employer for the use of this information and for any disclosures that may be made to the group health plan itself.

Health-Related Products and Services : We may use your health information to communicate with you about health-related products, benefits and services and payment for those products, benefits and services that we provide or include in our benefits plan, and about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in our network, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to, although they are not part of, our benefits plan. For example, we may contact you about a Medicare Supplemental policy when you near age 65.

Public Health and Benefit Activities: Although this does not occur often, we may use and disclose your health information when required by law and when authorized by law for the following kinds of public interest activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention enforcement agencies;
- for research in certain situations, such as when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Individual Rights

The following are your rights with respect to your health information. If you would like to exercise any of the following rights, please submit your request in writing, sign your request, and mail it to the Blue Cross and Blue Shield of Louisiana Privacy Office at P.O. Box 84656, Baton Rouge, LA 70884-4656. Our contact information is provided at the end of this Notice.

Access: You have the right to examine and to receive a copy of your health information we maintain about you in a "designated record set," with limited exceptions. You are not entitled to inspect and/or copy:

- any psychotherapy notes;
- any information compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding;
- any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a); or
- certain other records as specified in the HIPAA Privacy Regulation.

Generally, a "designated record set" contains:

- claims and payment information;
- enrollment and billing information;
- other records used to make decisions about your health care benefits.

We may charge you reasonable, cost-based fees for a copy of your health information, for mailing the copy to you, and for preparing any summary or explanation of your health information you may request. Contact us using the information at the end of this Notice for information about our fees. You may withdraw your request if you do not wish to pay the fees.

In certain situations we may deny your request to inspect and obtain a copy of your health information. If we deny your request, we will notify you in writing and will inform you whether or not you have the right to have the denial reviewed.

Disclosure Accounting: You have the right to an accounting of certain disclosures that we make of your health information after April 13, 2003, excluding disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities.

We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than six years before the date of your request and never for a disclosure that occurred before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. Contact us using the information at the end of this Notice for information about our fees.

Amendment: You have the right to request that we amend your health information that we maintain about you in your designated record set. We may deny your request for certain reasons. For example, we may deny your request if the information you want to amend was created by your doctor. If we deny your request, we will provide you a written explanation, and explain to you how you can disagree with the denial by filing a statement of disagreement with us. If we accept your request, we will make your amendment part of your designated record set, and use reasonable efforts to inform others of the amendment who we know may have relied on the unamended information to your detriment, as well as persons you tell us you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your health information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will honor our agreement, except in a medical emergency or as required or authorized by law. Any agreement we may make to a request for restriction must be in writing and agreed to by our Privacy Office.

Confidential Communication: If you believe that a disclosure of all or part of your health information may endanger you if sent to your current mailing address, you have the right to request that we communicate with you in confidence about your health information by a different means or to a different location that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.
We will accommodate your request if it is reasonable. You must specify the alternative means of contact or location for

confidential communication, and continue to permit us to collect premiums and pay claims under your health plan. Please note that other information that we send to the subscriber about health care benefits received may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence. If you have given someone else permission to receive health information about you, a request for confidential communications will cancel this permission unless you tell us otherwise.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you have the right to receive this Notice in written form. Please contact us using the information at the end of this Notice to obtain this Notice in written form.

Potential Impact of State Privacy Laws: The federal health care Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, or disclosure of health information of minors.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this Notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your health information, you may complain to us using the contact information at the end of this Notice. You also may submit a written complaint to the Secretary of the United States Department of Health and Human Services. We will provide you with the address to file your complaint with the United States Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

By mail:
Privacy Office
Blue Cross and Blue Shield of Louisiana
P.O. Box 84656
Baton Rouge, LA 70884-4656

Telephone: (225) 298-1751
Fax: (225) 295-2599

E-mail: Privacy.Office@BCBSLA.com
(Individual Rights requests will not be accepted via e-mail.)

Initial Notice about Special Enrollment Rights and Pre-existing Condition Exclusions

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) requires that we notify eligible plan participants about two (2) important plan provisions. The first notice is about the right to enroll in the plan under its "special enrollment provision" if you decline coverage or if you acquire a new dependent. The second notice advises you of the plan's "pre-existing condition exclusion rules" that may temporarily exclude coverage for certain pre-existing conditions.

Notice of Special Enrollment Rights

Loss of Other Coverage - If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing toward your or your dependents' other coverage). However, you must request enrollment within thirty (30) days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption - If you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents as special enrollees. However, you must request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your employer (plan administrator) or our Customer Service Center at 1-800-599-2583.

Notice of Pre-Existing Condition Exclusion Rules

This plan imposes a pre-existing condition exclusion. This means that if you have a medical or mental condition before coming to this plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This pre-existing condition exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the ninety (90) day period immediately prior to your enrollment date. Generally, this ninety (90) day period ends the day before your coverage becomes effective. However, if you were serving an eligibility waiting period for coverage, the ninety (90) day period ends on the day before the eligibility waiting period begins. The pre-existing condition exclusion does not apply to pregnancy (if your plan offers maternity coverage) nor to a child who is enrolled in the plan within thirty (30) days after birth, adoption, or placement for adoption.

(over)

This pre-existing condition exclusion period for medical conditions may last up to 180 days (eighteen (18) months if you are a late enrollee) from your first day of coverage or, if you were serving an eligibility waiting period, from the first day of your eligibility waiting period. The pre-existing condition exclusion period for mental disorders may last up to sixty (60) days. However, you can reduce the length of these exclusion periods by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion periods if you have not experienced a break in coverage of at least sixty-three (63) days. To reduce the exclusion periods by your creditable coverage, you should give us a copy of any Certificates of Creditable Coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show that you have creditable coverage. A Blue Cross and Blue Shield of Louisiana Prior Carrier Health Coverage Form (23XX1938) may be submitted for determination of creditable coverage in place of a Certificate of Creditable Coverage. Please contact us if you need help demonstrating creditable coverage.

If your group health plan is or becomes self-insured at the time of your request for enrollment into the plan, your pre-existing condition provisions may differ than stated above. For self-insured plans, the plan administrator is responsible for issuing the information on your pre-existing condition exclusion rules.

Each HIPAA Certificate (or other evidence of creditable coverage) may be reviewed to determine its authenticity. Submission of a fraudulent HIPAA Certificate would be considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to our Customer Service Center at 1-800-599-2583 between 8:00 a.m. and 5:30 p.m., Monday through Friday.

HMO Louisiana, Inc.
Enrollment Notice

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

This notice is applicable only to those enrolling for HMO or POS products.

HMO Louisiana, Inc. (HMOLA) is required to disclose the following information to its members upon enrollment. This disclosure provides you with general information about your HMO/POS plan. Please refer to your latest Schedule of Benefits for specific copayment and coinsurance amounts and network information. Your Contract or Certificate of Coverage includes specific information about your covered benefits.

Copayment and Deductible Amounts

As an HMOLA member, you are responsible for copayment and deductible amounts as outlined in your Contract or Certificate of Coverage. A copayment is a fixed dollar amount that you pay when you receive services from a network provider. Different co-pay amounts apply to primary care physicians and specialists. You are responsible for a copayment each time a specified covered service is rendered by a network provider. For POS plans and covered dependents living out of the service area, a deductible applies to out-of-network benefits. Please see your Contract or Certificate of Coverage for details.

Choice of Primary Care Physicians

HMOLA members must select a primary care physician (PCP) from the Louisiana Blue Health Plans network of physicians from the following specialties:

- Family Practice/General Practice: physicians who are trained in all aspects of primary medical treatment and are able to diagnose and treat patients in all age groups
- Internal Medicine: physicians who treat routine and complex adult medical conditions
- Pediatrics: physicians who specialize in the treatment of children

Members may choose a separate PCP for themselves, their spouse and each of their eligible dependents, or they may choose one PCP for the entire family.

Direct Access to Specialists

Our HMOLA members may access most network specialists directly, without a referral from your PCP. Members with mental health benefits must obtain authorization from Magellan Health Services for mental health services, which is explained in your Contract or Certificate of Coverage. Your Contract or Certificate of Coverage also defines other specialists and services that require authorization prior to obtaining services.

Application of Pre-existing Conditions

For group plans, treatment of any pre-existing condition is not covered unless your treatment is rendered after a 180-day period during which you are continuously covered under the contract.
For mental disorders, this period is 60 days. For late enrollees, treatment of pre-existing conditions, with the exception of mental disorders, is not covered for 18 months from enrollment in the plan.

If your group plan is self-insured, your plan's pre-existing condition period may be different than stated above. Please see your Contract or Certificate of Coverage for details.

For individually purchased plans, treatment of any pre-existing condition is not covered for 365 days from enrollment in the plan.

All pre-existing condition exclusion periods may be reduced for time served under a prior plan's health coverage as per state and federal guidelines.

If you have any questions about this disclosure or your HMOLA coverage, please call Customer Service at 1-800-376-7741 between 8:30 a.m. and 4:00 p.m., Monday through Friday.

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