Louisiana

APPLICATION FOR INDIVIDUAL COVERAGE

HMO Louisiana

OFFICE USE ONLY					
CONTRACT NUMBER		CONTRACT DATE	LIST BILL NUMBER	PARISH	AREA CD.
TOTAL FEES	U.W. INT. DATE		MED. INFO. ON FILE	REQUESTED EFF. DATE	AGENT#

BLUE CROSS AND BLUE SHIELD OF LOUISIANA PRODUCTS: CHOOSE ONE

Blue Max: ❑ $1800 ❑ $2800 ❑ $5000 **Blue Saver:** Single ❑ $3100 ❑ $4500 Family ❑ $6200 ❑ $9000

HMO OF LOUISIANA PRODUCTS: CHOOSE ONE PLAN BELOW

Blue Point of Service: ❑ $1000 ❑ $3000 ❑ $3100 ❑ $3500 ❑ $4500 ❑ $6500 **Community Blue:** ❑ $1000 ❑ $3500 ❑ $4500 **BlueConnect:** ❑ $1000 ❑ $3000 ❑$3500
Blue Connect Acadiana: ❑ $3000 ❑ $3500 ❑ $4500

NOTICE: 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.

ANCILLARY PRODUCTS:

Variable Income Plan (VIP) Preferred: ❑ $100 ❑ $200 ❑ $250
Budget: ❑ $100 ❑ $200 ❑ $250 **Senior:** ❑ $100 per day

Cancer and Serious Disease (CSD)
❑ Plan F Comprehensive 80 ❑ Plan G Comprehensive 50

Blue Dental Certified: ❑ Preferred ❑ Essential ❑ Value
Blue Dental Traditional: ❑ Preferred ❑ Essential ❑ Value

LIST BILL: ❑ Yes, Company Name and Number

OTHER COVERAGE

Have you or your dependent(s) had other medical coverage within the last 60 days? ❑ Yes ❑ No Policyholder _____ Contract No. _____ Insurance Co. _____ Termination Date _____
Do you or your dependent(s) have other dental coverage? ❑ Yes ❑ No Policyholder _____ Contract No. _____ Insurance Co. _____ Termination Date _____
Have you or your dependent(s) had Blue Cross individual dental coverage in the last 12 months? ❑ Yes ❑ No Policyholder _____ Contract No. _____ Termination Date _____
Does anyone on this application have Medicare A or B ❑ Yes ❑ No Policyholder _____

APPLIES TO ALL PRODUCTS

Have you used any form of tobacco including electronic cigarettes 4 or more times a week in the last 6 months excluding religious or ceremonial uses? (Only for 18 year or older) ❑ Yes ❑ No

Spouse ❑ Yes ❑ No | Dependent 1 ❑ Yes ❑ No | Dependent 2 ❑ Yes ❑ No | Dependent 3 ❑ Yes ❑ No | Dependent 4 ❑ Yes ❑ No

Social Security No.	Last Name (Print)	First (Print)	MI	AC ( ) Phone No.

Physical Address	City	State	Zip Code	**Email Address	AC ( ) Mobile No. ***❑ Opt In

Mailing Address	City	State	Zip Code	Date of Birth Month / Day / Year	❑ Male ❑ Female	Marital Status ❑ Single ❑ Married ❑ Other

COMPLETE THIS SECTION ONLY IF DEPENDENTS ARE TO BE COVERED

Last Name	First Name	MI	Relationship	Med	Dental	VIP	CSD	**Email Address	Social Security Number	Date of Birth Mo	Day	Year
Spouse			❑ Husband ❑ Wife	❑	❑	❑	❑					
Dependent 1			❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other*_____	❑	❑	❑	❑					
Dependent 2			❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other*_____	❑	❑	❑	❑					
Dependent 3			❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other*_____	❑	❑	❑	❑					
Dependent 4			❑ Son ❑ Stepson ❑ Daughter ❑ Stepdaughter ❑ Other*_____	❑	❑	❑	❑					

*If you have checked "Other" and this is an adoption or guardianship, please submit legal papers.
**Email addresses are being collected to enable Blue Cross and Blue Shield of Louisiana to communicate with you electronically. Once enrolled for coverage, you will be able to manage your communication preferences. Minors will not receive electronic communications directly, however, if contact information for a legally responsible party is provided for a minor, that individual may receive electronic communications on behalf of the minor.
***By submitting my mobile number, I agree to receive information via text about my account and general marketing messages from BCBSLA.

PRIMARY CARE PHYSICIAN (PCP) SELECTION (complete if enrolling in Community Blue or Blue Connect products)

APPLICANT NAME	PHYSICIAN NAME	PHYSICIAN ADDRESS

IMPORTANT! Any personal health information (PHI) obtained by Blue Cross and Blue Shield of Louisiana in connection with this application may be retained by Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc., and used or disclosed in connection with future underwriting or renewal efforts. If you answer "yes" to any medical questions, please answer questions according to medical guidelines.

VARIABLE INCOME PLAN (VIP)

Your Height: _____ Your Weight: _____ Spouse's Height: _____ Spouse's Weight: _____

IF APPLYING FOR VIP COVERAGE, PLEASE ANSWER QUESTIONS BELOW. *See VIP Medical Guide Questionnaire.

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. HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC? ❑ Yes ❑ No
11. Hepatitis or a liver disorder? ❑ Yes ❑ No
12. Any bodily deformities? ❑ Yes ❑ No
13. Kidney stones or urinary system disorders, diabetes insipidus or prostate disorders? ❑ Yes ❑ No
14. Ulcers, stomach, colon or other intestinal disorders, adhesions? ❑ Yes ❑ No
15. A mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation? ❑ Yes ❑ No
16. Alcohol or substance abuse, detoxification? ❑ Yes ❑ No
17. Are you presently taking medications? ❑ Yes ❑ No
18. 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

CANCER AND SERIOUS DISEASE (CSD)

FOR CANCER AND SERIOUS DISEASE APPLICANTS: Have you or the persons on whose behalf this application is made had, or presently have cancer, leukemia, encephalitis, spinal meningitis, sickle cell anemia, tetanus, diptheria, poliomyelitis or rabies. ❑ Yes ❑ No If yes, list name, disease, remission date and date diagnosed. (Below)

NAME	TYPE OF DISEASE	DATE DIAGNOSED	REMISSION DATE

METHOD OF PAYMENT:

Initial Payment

❑ Check $_____ ❑ Money Order $_____ ❑ Bank Draft ❑ Credit Card

Recurring

❑ Bank Draft (Monthly)

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.

1. I, the undersigned, do hereby apply for coverage with Blue Cross and Blue Shield of Louisiana (BCBSLA) or HMO of Louisiana, Inc., for myself and my family members listed on this application. I understand that this application, any Change of Status Card, and my contract policy, together with the certificate of coverage, any endorsements issued by BCBSLA or HMO of Louisiana, Inc. may be terminated within three years of the original effective date of the member's coverage and all fees, less claims paid, will be refunded if I committed fraud or intentional misrepresentation of material fact in this application.
2. I PROXY-I hereby constitute and appoint the directors present in person or by proxy given to another director(s), to vote on my behalf at membership meetings on any matters on which policyholders are entitled to vote. I acknowledge notice that the annual meeting of the policyholders is held on the third Tuesday in February or on the next business day following, if a legal holiday. Notice of any such meeting given to such director(s) constitutes notice to me. Payment of each premium extends the proxy's effectiveness unless revoked by the policyholder as hereafter provided. I understand that if I revoke my proxy, I may continue to pay my premium without affecting the revocation or my coverage. I understand that I may designate any other policyholder as my proxy by sending any form of writing to Louisiana Health Service & Indemnity Company at P.O. Box 98029, Baton Rouge, Louisiana 70898. Check this block if you do not want to grant your proxy. ❑
3. All information I provided herein is true and correct to the best of my knowledge, information and belief.
   I understand that this is an application for coverage and is not binding on BCBSLA. I understand that BCBSLA reserves the right to set the effective date for any Contract issued and that the Contract will not become effective until that date is established by BCBSLA.
4. Premiums must be paid in US dollars. Policyholder will be assessed a $25 NSF fee should its premium be paid with a check that is returned by the bank due to insufficient funds. If multiple payments are returned by the bank, Company may at its sole discretion refuse to reinstate coverage.

Please open a MySmartSaver Health Savings Account: ❑ Yes ❑ No

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 application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I have personally obtained the information shown on this application.

Producer's Signature _____ Date _____

Print Name _____ Phone No. _____

Producer's Email Address _____

❑ Taken over the phone

If applying for CSD or VIP coverage, 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.

VIP APPLICANTS ONLY: I understand that I must have minimum essential health coverage to receive any benefits from a VIP policy. I acknowledge that I have other health coverage that meets the requirement of minimum essential coverage.

Applicant's Signature _____ Date _____

Print Name (Applicant) _____ Relationship to Applicant _____

INDIVIDUAL MEDICAL POLICY DISCLOSURE NOTICE

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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CANCER AND SERIOUS DISEASE POLICY DISCLOSURE NOTICE

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- hospital or medical expenses up to the maximum stated in the policy.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

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Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@bcbsla.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

   Section 1557 Coordinator
   P. O. Box 98012
   Baton Rouge, LA 70898-9012
   225-298-7238 or 1-800-711-5519 (TTY 711)
   Fax: 225-298-7240
   Email: Section1557Coordinator@bcbsla.com

2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.
إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ຫ່ານຟຣີ. ຖ້າຫ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ຫ້ງຂອງບັດປະຈຳຕົວຂອງຫ່ານ. ຖ້າຫ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔ سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید. مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)