HMO Louisiana, Inc.

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

APPLICATION FOR INDIVIDUAL HMO/POS HEALTH COVERAGE

01 ______ 02 ______ 03 ______ 04 ______

OFFICE USE ONLY								
CONTRACT NUMBER	CONTRACT DATE	GROUP NUMBER	MOP	WC	CLASS	CONTROL NUMBER		PARISH
ENROLL	RATE CODE	TOTAL FEES	CONVERSION DATE	U.W. INT.	DATE	CLERK	MED. INFO. ON FILE	AREA CD.
							REQUESTED EFF. DATE	AGENT# 96211

LIST BILL: ☐ YES, COMPANY NAME AND NUMBER

SOCIAL SECURITY NO.	LAST NAME (Print)	FIRST (Print)	MIDDLE (Print)	AC ( ) PHONE NO.
STREET ADDRESS	CITY	STATE	ZIP CODE	DO YOU WANT COMBINED BILLING? ☐ YES ☐ NO
DATE OF BIRTH MONTH DAY YEAR	☐ MALE ☐ FEMALE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER	OCCUPATION	

COMPLETE THIS SECTION ONLY IF DEPENDENTS ARE TO BE COVERED

DEPENDENT'S FULL NAME (Include first, last, mi)	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO DAY YR	IF DEPENDENT CHILD IS OVER 20, INDICATE IF FULL-TIME STUDENT. IF DEPENDENT IS NOT NATURAL CHILD, ATTACH CERTIFIED DOCUMENTATION OF LEGAL CUSTODY OR ADOPTION.	FULL-TIME STUDENT	DEPENDS UPON YOU FOR SUPPORT?	DATE DEPENDENCY BEGAN	RESIDES WITH YOU?
SPOUSE			☐ HUSBAND ☐ WIFE				
			☐ SON ☐ STEPSON ☐ DAUGHTER ☐ STEPDAUGHTER ☐ OTHER ______	☐ YES ☐ NO	☐ YES ☐ NO		☐ YES ☐ NO
			☐ SON ☐ STEPSON ☐ DAUGHTER ☐ STEPDAUGHTER ☐ OTHER ______	☐ YES ☐ NO	☐ YES ☐ NO		☐ YES ☐ NO
			☐ SON ☐ STEPSON ☐ DAUGHTER ☐ STEPDAUGHTER ☐ OTHER ______	☐ YES ☐ NO	☐ YES ☐ NO		☐ YES ☐ NO
			☐ SON ☐ STEPSON ☐ DAUGHTER ☐ STEPDAUGHTER ☐ OTHER ______	☐ YES ☐ NO	☐ YES ☐ NO		☐ YES ☐ NO
			☐ SON ☐ STEPSON ☐ DAUGHTER ☐ STEPDAUGHTER ☐ OTHER ______	☐ YES ☐ NO	☐ YES ☐ NO		☐ YES ☐ NO

OUT OF AREA DEPENDENT(S) NAME(S) AND (CITY AND STATE): ______

☐ For dependents residing out of the subscriber's Louisiana Blue Health Plans Service Area and who would like to be covered under Dependent Out-of-Area Benefits, please complete an HMO Louisiana Dependent Certification form (04100 00066) available from your agent or by calling 1-800-376-7741 and submit with this application.

METHOD OF PAYMENT (List Bill Must Be Monthly)	
☐ MONTHLY ☐ SEMI-ANNUAL-LY ☐ QUARTERLY ☐ ANNUALLY ☐ BANK DRAFT	DO YOU OR YOUR DEPENDENTS HAVE, OR HAD WITHIN 63 DAYS, OTHER HEALTH INSURANCE INCLUDING MEDICARE? ☐ YES ☐ NO IF YES, GIVE CONTRACT NUMBER AND PLAN NAME: ______ IF COVERAGE WITHIN 63 DAYS (PORTABILITY), COMPLETE FORM 01100 00040. HAVE YOU/DEPENDENT EVER HAD BLUE CROSS AND BLUE SHIELD COVERAGE? ☐ YES ☐ NO POLICYHOLDER NAME ______ POLICY NUMBER ______

BENEFIT DESIGN: CHECK CLASS AND COMPLETE ONE OF THE FOLLOWING PLANS

CLASS (CHECK ONE) ☐ APPLICANT ONLY ☐ APPLICANT AND SPOUSE ☐ APPLICANT AND ELIGIBLE CHILDREN ☐ APPLICANT AND SPOUSE AND ELIGIBLE CHILDREN (FAMILY)

HMO/POS

☐ **PLAN 1** $20 COPAY ☐ **PLAN 2** $25 COPAY ☐ **PLAN 3** $30 COPAY ☐ **PLAN 4** $35 COPAY ($500 Pharm. Ded.) ☐ **PLAN 5** $35 COPAY ($1000 Ded.)

HAVE YOU USED TOBACCO IN ANY FORM WITHIN THE LAST 12 MONTHS? ☐ YES ☐ NO

HAS YOUR SPOUSE USED TOBACCO IN ANY FORM WITHIN THE LAST 12 MONTHS? ☐ YES ☐ NO

RISK LEVEL: ☐ PREFERRED ☐ STANDARD 1 ☐ STANDARD 2 ☐ STANDARD 3

SUBMITTED WITH APPLICATION: $______ PERSONAL CHECK $______ MONEY ORDER
$______ OTHER, EXPLAIN ______

1. I the undersigned, do hereby apply for membership in HMO Louisiana, Inc. (HMOLA), for myself and my dependents, if any, listed on this application. If the application is accepted, a contract will be issued. I understand that this application, any Change of Status Card and Contract, together with any riders and endorsements issued by HMOLA constitute my contract with HMOLA. I understand the contract as it pertains to me and my dependents may 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 exists in the application or any Change of Status Card.
2. The information given herein is true and correct, to the best of my knowledge and belief.

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, WHEN REQUIRED.

IMPORTANT! Please answer all questions below for all persons included in this application. For each positive response, underline the appropriate statement or condition and complete the medical questionnaire on page 3. Any personal health information (PHI) obtained by HMO Louisiana Inc. in connection with this application may be retained by HMO Louisiana Inc. and used or disclosed in connection with future underwriting or renewal efforts.

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.

I have personally obtained the information shown on this application.

Producer's Signature _____ Date _____

Patricia Freeman (225)622.6554

Print Name Phone No.

trish@insurancelady.com

Producer's E-Mail Address

Met with applicant in person: ❑ Yes ❑ No

Physical Requested: ❑ Yes ❑ No

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.

Applicant's Signature _____ Date _____

Print Name (Applicant) _____ E-Mail Address _____

Relationship to Applicant _____

BlueCross BlueShield of Louisiana

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

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AUTHORIZATION FOR ENROLLMENT OR ELIGIBILITY

Instructions: This form is used for you to authorize any health care provider, pharmacy, pharmacy related service provider, health care data aggregator and similar entity permission to release your protected health information to Blue Cross and Blue Shield of Louisiana and its subsidiary HMO Louisiana, Inc. (collectively referred to as "BCBSLA") for the purpose of underwriting or risk-rating of health insurance coverage for you, or to determine your eligibility for enrollment or benefits under a health plan. Please complete the information in Section A for you, your spouse, or any dependents who are proposed for coverage. You, your spouse, and any dependents 18 years old or older must sign Section C.

Section A: Applicant Information

List the specific person(s) whose information is to be released.

Name: _____ Date of Birth _____

Address: _____

City: _____ State: _____ Zip _____

Spouse's Name _____ Date of Birth _____

Dependent Name _____ Date of Birth _____

Dependent Name _____ Date of Birth _____

Section B: Important Information

Purpose: I (we) grant permission to any healthcare provider, pharmacy, pharmacy related service provider, health care data aggregator and similar entity permission to release protected health information (PHI) to BCBSLA for the purpose of underwriting or risk-rating of health insurance coverage for me (us), or to determine my (our) eligibility for enrollment or benefits under a health plan.

Protected Health Information to be disclosed: I (we) understand that my (our) PHI may include, but is not limited to information relating to any of the following: prescription medication, medical history, mental health (excluding psychotherapy notes), pregnancy/maternity, organ transplants and chemical dependency (including alcohol and drug abuse).

Effect of Declining this Authorization: This authorization is a condition of your enrollment in or eligibility for benefits under a health plan. If you decide not to sign this authorization, we may decline to enroll you in a health plan or to give you the benefits.

Further disclosure: BCBSLA is required to follow the federal health information privacy laws, however if the information received is subject to redisclosure to other entities it may no longer be protected by the federal health information privacy laws.

Expiration: This authorization will automatically expire after 1) all processing of your application and subsequent requests relating to your coverage are completed; or 2) if you are enrolled in the health plan, after completion of all claims processing or other activities relating to the terms of coverage under the health policy are completed.

Right to Revoke: You may take back your permission to allow BCBSLA to obtain your information with those listed on this form by contacting the Privacy Office at 5525 Reitz Avenue, Baton Rouge, LA 70809-3802. Taking back your permission will not affect any action taken before we received your letter.

Section C Signature(s)

I, _____, have read and thought about the contents of this form. I agree that the information I put on this form is correct. I understand that by signing this form I am giving permission to BCBSLA to obtain my protected health information for the purpose of underwriting or risk-rating of health insurance coverage, or to determine eligibility for enrollment or benefits under a health plan.

Signature _____ **Date** _____
(Note: Signature must be that of the person listed in Section A)

Spouse's Signature _____ **Date** _____
(Spouse's signature is needed if spouse is part of application).

Dependent Signature _____ **Date** _____
(Dependent signature needed if dependents are 18 years old or older).

Dependent Signature _____ **Date** _____
(Dependent signature needed if dependents are 18 years old or older).

If this authorization is signed by a personal representative* on behalf of the person, complete the following: Personal Representative's Name _____
Relationship to the individual: _____
Attach legal documentation of guardianship or Power of Attorney

*Personal representative is a legal designation and generally refers to the parent of a minor, legal guardian, or holder of Power of Attorney).

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT

For Office Use Only Application #_____

BlueCross BlueShield of Louisiana

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PRIOR CARRIER HEALTH COVERAGE FORM

COMPLETE IN BLACK INK ONLY

Prior carrier coverage is used to reduce pre-existing condition exclusion periods by giving credit for time served under qualified plans. This form may be submitted for creditable coverage determination in place of a Certificate of Creditable Coverage (if permitted by the group employer plan). In order to correctly calculate creditable coverage, it is critical the information you provide is accurate, otherwise claim benefit determinations may be incorrect. You can call your prior carriers or prior employers to obtain the needed information. Please complete this form for each prior carrier enrollment occurring within the last 24 months for both you and your dependents. This form may also be used to report prior carrier dental coverage information if you are enrolling into a group dental plan. **NOTE: Do not complete this form for limited scope policies such as vision, long-term care, specified disease (e.g. cancer), fixed indemnity (e.g. $100 per day) since they are not qualified plans.**

INSTRUCTIONS

Section 1: Personal Information: Please provide your name, social security number, daytime phone number, your current Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. group policy number, if known.

Section 2a: Prior Carrier Information: Provide the requested prior carrier information.

Section 2b: Member Information: Do not complete the last two columns of this section (*If Group Policy, If Individual Policy)* if you and your dependents have been covered under your prior plan for 18 months or more. If coverage under the prior plan is less than 18 months, we require an additional date in order to determine whether coverage is creditable. Use the following instructions to determine what date should be provided. If you and your dependents enrolled into your *prior group health plan* when initially offered, generally upon hire, then you must also provide the date your waiting period began or if applicable, your plan affiliation date. If you or your dependents enrolled into the prior group plan as a late or special enrollee, you have no waiting period, therefore indicate "N/A". If your prior coverage is under an *individual policy (*a plan not sponsored by an employer) then you must provide the date you submitted a substantially complete application to the carrier.

If you have not yet terminated the other coverage, please give the date the coverage will be terminated (additional information may be requested at the time of termination).

Waiting Periods When Coverage Never Becomes Effective: Because waiting periods do not count as lapses in coverage, you possibly could have additional creditable coverage that may be added to qualifying creditable coverage identified through using this form. Please speak to your agent or broker if within the last 24-month period, you terminated employment during your group's waiting period OR if within the last 24-month period, your application for an individual policy did not become effective due to either your or the issuer's rejection. The agent should assist you in determining whether we need to adjust your creditable coverage calculation.

SECTION 1: PERSONAL INFORMATION

NAME	SOCIAL SECURITY NUMBER

DAYTIME PHONE NUMBER	CURRENT GROUP NUMBER, IF APPLICABLE

SECTION 2A: PRIOR CARRIER INFORMATION

PRIOR CARRIER NAME	ADDRESS

POLICY NUMBER	PRIOR CARRIER PHONE NUMBER	PLAN TYPE: ❑ Group Employer Plan ❑ COBRA ❑ Individual Plan ❑ Other (describe) _____

SECTION 2B: PRIOR CARRIER MEMBER INFORMATION

NAME	Date of Birth	Dependent Relationship to Subscriber (son, daughter, step-son, etc)	Coverage For: H-Health D- Dental	Coverage Effective Date M/D/Y	Coverage Termination Date M/D/Y	***If Group Policy,*** Date waiting period/affiliation period began M/D/Y (if any) or N/A	***If Individual Policy,*** Date a Substantially Complete Application Submitted M/D/Y or N/A
SUBSCRIBER							
SPOUSE							

(OVER)

NAME	Date of Birth	Dependent Relationship to Subscriber (son, daughter, step-son, etc)	Coverage For: H-Health D- Dental	Coverage Effective Date M/D/Y	Coverage Termination Date M/D/Y	***If Group Policy,*** Date waiting period/affiliation period began M/D/Y (if any) or N/A	***If Individual Policy,*** Date a Substantially Complete Application Submitted M/D/Y or N/A
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							

SECTION 3: AUTHORIZATION & CERTIFICATION BY SUBSCRIBER

I authorize Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. to verify all information provided with my prior carriers or employers. I attest that the information given on this form is accurate and true to my knowledge, and that I will refund immediately any monies paid in error by Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. as a result of misrepresented information on this form.

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.

Subscriber Signature _____ Date _____

HMO Louisiana, Inc.

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AUTHORIZATION TO DRAW CHECKS ON MY ACCOUNT

As a convenience to me, I authorize HMO Louisiana, Inc. to start an automatic monthly charge to my account at the Bank (or other financial institution) I have named. I also authorize the Bank to debit the amount of those charges to my account.

I understand and agree that:

1. The Bank's rights with respect to each charge will be the same as if personally executed by me.
2. This authorization will remain in effect until I provide written notification to HMO Louisiana, Inc. that I wish to revoke it. I will allow HMO Louisiana, Inc. thirty (30) days to act on this notice.
3. HMO Louisiana, Inc. and my bank may discontinue this service.
4. I understand that if any such check is dishonored by my Bank and any monthly amount due HMO Louisiana, Inc. is not paid within the time stipulated in the policy, the policy could be terminated as provided in the policy.

X _____

(Name - Please Print)

X _____

(Signature) (Date)

_____

(Contract Number or Application Number)

_____

(Name of Bank or Financial Institution) (City)

_____

(Checking Account Number)

_____

(Routing Number)

Attach Blank Check Marked "Void"

Fax to: (225) 298-1609

Note: *Your account cannot have any amount currently due in order for a bank draft to be set up.*

01100 00855 0209R