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.

APPLICATION FOR GROUP COVERAGE

❑ NEW GROUP ❑ NEW SUB-GROUP ❑ DUAL CHOICE

SECTION A - COVERAGE SELECTION

Blue Cross and Blue Shield of Louisiana

❑ PPO (Ded/Coins.) ________ ❑ Premier Blue (Plan #) ________
❑ Blue*Saver* (Ded/Coins) ________ ❑ Dental (Plan #) ________
❑ TrueBlue (Ded/Coins.) ________ ❑ Other (Plan #) ________
*Domestic Partnership Coverage? ❑ Yes ❑ No

HMO Louisiana, Inc.

❑ HMO (Plan #) ________
❑ POS (Plan #) ________

Southern National Life Insurance Company, Inc.

❑ Life/AD&D ❑ Life Only
❑ Dependent Life
❑ Short Term Disability
*Domestic Partnership Coverage? ❑ Yes ❑ No

** Available same sex only for groups with 100 + Enrolling Contracts*

Association: ❑ Yes ❑ No: If yes: ❑ LABI ❑ LADA ❑ LIFA ❑ LMA

SECTION B - GROUP INFORMATION

Group/Policyholder (Full Legal Name)	Requested Effective Date	Underwriting Code

Contact Name and Title (To list additional contacts, please do so in the "Notes" section.)	Group Number	Sub-Group

Physical Address	City	State	Zip Code	Telephone Number
Mailing Address	**City**	**State**	**Zip Code**	**Fax Number**

Federal Tax ID Number	Company E-Mail Address	Type of Business

Name of previous carrier Medical ________________ Dental ________________

Are you a church plan? ❑ Yes ❑ No
Are you a government plan? ❑ Yes ❑ No
Are you collectively bargained? ❑ Yes ❑ No

Method of Payment
❑ Monthly ❑ Other ________________

❑ Age Rated
❑ Composite

Fully Insured: ❑ Yes ❑ No
Other Financial Arrangement:

Mental Disorders
❑ Included ❑ Excluded

Alcohol and Substance Abuse Services
❑ Included ❑ Excluded

Group Subject to:
❑ COBRA ❑ State Continuation

Pregnancy Coverage (required by federal law if 15 or more employees) ❑ Included ❑ Excluded

SUBGROUP/LOCATIONS ❑ None ❑ Yes - List names and addresses below

Name	Address

SECTION C - CONTRIBUTION/WAITING PERIOD/PARTICIPATION

Employer Contribution (either in percentage or dollar amounts)

	Employee		Dependent		
Medical	Employee	%	Dependent	%	$
Dental	Employee	%	Dependent	%	$
Life/AD&D	Employee	%	Dependent	%	$
Short Term Disability	Employee	%	Dependent	%	$
Dependent Life			Dependent	%	$

Pre-Existing Condition Exclusion Periods

1. The Standard Pre-Existing Exclusion Period applies to all BCBSLA and HMOLA fully-insured groups.
2. Administrative Services Only groups may choose other options.
3. The pre-existing exclusion period for mental disorders is limited to 60 days.
4. No Pre-Ex applies to any person under age 19.

Initial ❑ Standard ❑ No Exclusion Period
❑ Other ________________________________

Subsequent ❑ Standard ❑ No Exclusion Period
❑ Other ________________________________

Participation

	No. Total Eligible	No. Total Ineligible	No. Serving Eligibility	No. COBRA/LA Continuation	No. Retirees Covered	No. Spousal Elsewhere Credits	No. Waivers	No. Life Only	Total No. Enrolled
Health									
Dental									
Life									

ATTACH SIGNED MEDICAL, DENTAL AND LIFE PROPOSALS FOR COVERAGES SELECTED
ADMINISTRATIVE SERVICES ONLY (ASO) AND NON-STANDARD FULLY-INSURED GROUPS: YOUR GROUP MEDICAL BENEFITS CHECKLIST MUST BE ATTACHED

SECTION D - ELIGIBLITY

Are Owners Eligible for Coverage? ❑ Yes ❑ No   Are Elected Officials Eligible for Coverage? ❑ Yes ❑ No

Initial Employee Eligibility for Medical, Dental and Life/AD&D Coverage (check one only)								Subsequent Employee Eligibility for Medical, Dental and Life/AD&D coverage (check one)					
Eligibility Class		First billing date on or after:					Medical Product Selection	Date of Hire	First billing date on or after:				
	Date of Hire	Date of Hire	1 Mo.	2 Mo.	3 Mo.	Other			Date of Hire	1 Mo.	2 Mo.	3 Mo.	Other
❑ Active	❑	❑	❑	❑	❑			❑	❑	❑	❑	❑	
❑ Mgmt.	❑	❑	❑	❑	❑			❑	❑	❑	❑	❑	
❑ Non-Mgmt	❑	❑	❑	❑	❑			❑	❑	❑	❑	❑	
❑ Retirees	❑	❑	❑	❑	❑			❑	❑	❑	❑	❑	
❑ COBRA/State Cont.	❑	❑	❑	❑	❑			❑	❑	❑	❑	❑	
❑ Other	❑	❑	❑	❑	❑			❑	❑	❑	❑	❑	

ADDITIONAL CLASSES (if applicable, explain below)

Initial Employee Eligibility for Medical, Dental and Life/AD&D Coverage (check one only)								Subsequent Employee Eligibility for Medical, Dental and Life/AD&D coverage (check one)					
Eligibility Class		First billing date on or after:					Medical Product Selection	Date of Hire	First billing date on or after:				
	Date of Hire	Date of Hire	1 Mo.	2 Mo.	3 Mo.	Other			Date of Hire	1 Mo.	2 Mo.	3 Mo.	Other
	❑	❑	❑	❑	❑			❑	❑	❑	❑	❑	
	❑	❑	❑	❑	❑			❑	❑	❑	❑	❑	
	❑	❑	❑	❑	❑			❑	❑	❑	❑	❑	
	❑	❑	❑	❑	❑			❑	❑	❑	❑	❑	
	❑	❑	❑	❑	❑			❑	❑	❑	❑	❑	

Prior Carrier Eligibility for Medical

Prior Carrier Eligibility for Dental

Prior Carrier Eligibility for Life/AD&D

SECTION E - SOUTHERN NATIONAL LIFE

1. **POLICYHOLDER:**

   ADDRESS

   SUBSIDIARY AND AFFILIATED COMPANIES

2. **CLASSES OF FULL-TIME EMPLOYEES EXCLUDED:** (If none, please state)

3. **SCHEDULE OF BENEFITS:**

CLASS OF EMPLOYEES	LIFE INSURANCE LIFE AMOUNT	A.D.& D. INSURANCE A.D.& D. AMOUNT	S.T.D. AMOUNT/MAXIMUM

4. ACCIDENTAL DEATH AND DISMEMBERMENT:

❑ Occupational and Non-Occupational Coverage ❑ Non-Occupational Coverage ❑ None

5. SHORT TERM DISABILITY BENEFITS:

❑ Non-Occupational Coverage ❑ Pregnancy Included ❑ Pregnancy Not Included ❑None

.

Benefits Begin On The	Day of Accident Disability and on the	Day of Sickness Disability
Benefits Continue For a Maximum Period of	Weeks	
Short Term Disability Benefits Terminate at Retirement or Age		Whichever Occurs First

6. DEPENDENT LIFE:

❑ Yes ❑ No If Yes, the following will apply

$ ________________Spouse

Amount on each dependent child to be determined by the age of each child at the date of death as shown below:

$ Starting at Birth	$ Starting at 14th day	$ Starting at 6th Month

Dependent life benefits terminate at employee's retirement or age ________________ , whichever comes first.

7. EMPLOYEE TERM LIFE AND A.D.& D. INSURANCE:

Benefits reduce ____________________ % at age 65 and ________________ % at age 70;

or ____ and

terminate at retirement or age ________________________, whichever comes first.

8. **IF THE LIFE INSURANCE APPLIED FOR** replaces any such insurance now or previously in force within the past year with another company covering employees eligible for this insurance, please indicate the name of the carrier below.

NAME OF PREVIOUS CARRIER

DATE TO WHICH PREMIUMS PAID

Notes:

SECTION F - GROUP AGREEMENT

BY ACCEPTING BENEFITS UNDER THIS BENEFIT PLAN, GROUP/POLICYHOLDER AGREES TO THE FOLLOWING:

1. It is agreed that the Group will maintain standard percentage of enrollment which is 75% or ____________of all eligible employees.
2. It is agreed that new employees will enroll for coverage immediately, to be effective according to the eligibility requirements stated in the Benefit Plan, with the employer paying a minimum of 50% or ___________ of each employee's premium.
3. New employees who do not exercise the option to enroll self or dependents during their initial period of eligibility will be subject to the eligibility requirements stated in the Benefit Plan.
4. It is agreed that the effective date of the Benefit Plan and of an employee's coverage will be subject to the approval of our home office.
5. It is agreed that Blue Cross and Blue Shield of Louisiana and its subsidiaries will be the exclusively endorsed carriers for comprehensive medical coverage.
6. All subscribers in the Group are full-time employees (30 hours per week minimum) or ___________, except for retirees less than age sixty-five (65), unless the Company's records designate otherwise.
7. All information provided on this application, payroll records, and/or SUTA form are correct to the best of my knowledge.
8. The Group will notify Our Membership & Billing Department of the termination of Members from coverage within 30 days of the date on which the member is terminated from the Group.
9. The Group will submit to Our Membership & Billing Department, evidence of a Member's election of any applicable COBRA or other continuation of coverage following such termination within three (3) business days of the Group's receipt of signed continuation forms from the Member.
10. This document certifies that the Group was offered: coverage the same as any other illness for mental disorders and substance abuse.
11. I recognize BCBSLA and HMOLA Producer # ______________ as the producer of record for my Group's benefit plan and acknowledge that the producer may receive commissions as indicated below.

    ❑ 10% graded commission
    ❑ 9% graded commission (LABI Only) [ ] Group Contact Initials
    ❑ Other* _______________

    I also acknowledge that producer may receive additional compensation and/or incentives based on other factors such as growth, premium volume, and loss ratio or claims experience. The additional compensation may be from 0 to 4 percent, with an average of 2 percent.
12. If enrolled with Southern National Life Insurance Company, Inc., it is understood and agreed that the life policy, if issued, shall include administrative provisions applicable to the life insurance; that such administrative provisions shall be binding upon the Group/Policyholder and Southern National Life Insurance Company, Inc., subject to all of the provisions of the life policy; and that this application shall form part of the contract to be issued by Southern National Life Insurance Company, Inc.
13. If enrolled with Blue Cross and Blue Shield of Louisiana, on behalf of the Group, I hereby constitute and appoint the directors of Louisiana Health Service & Indemnity Company, present in person or by proxy given to another director(s), to vote, on behalf of the Group, at membership meetings on any matters on which policyholders are entitled to vote. **I acknowledge 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 this proxy is revoked, the premium may continue to be paid without affecting the revocation of the Group's coverage. I understand that any other policyholder may be designated a proxy by sending any form of writing to the Plan at P. O. Box 98029, Baton Rouge, Louisiana 70898-9029. I also hereby acknowledge that I am authorized by the Group to grant such proxy on behalf of the Group. **Check this block if you do not want to grant this proxy. ❑**
14. Group agrees that it was not formed primarily for purposes of buying health insurance.

*Level commissions are an option for LABI cases of 50 lives or more.

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.

Group/Policyholder Signature _________________________________ Date _________________________________

Producer Signature ____________________________ Producer Number _________ Date _________________________________

Company Representative Signature ________________________________ Date _________________________________

Underwriter Approval ________________________________ Date _________________________________