Louisiana

INDIVIDUAL CHANGE OF STATUS CARD

HMO Louisiana

AGENT'S NAME	AGENT'S NUMBER

01 _____ 02 _____ 03 _____ 04 _____

SUBSCRIBER: PLEASE COMPLETE THIS SECTION

LAST NAME (PLEASE PRINT)	FIRST NAME	M.I.	CONTRACT NO.
DAY TIME PHONE NO.	ARE YOU OR ANY OF YOUR DEPENDENTS CURRENTLY RECEIVING DISABILITY/WORKERS' COMP. BENEFITS? ❑ YES ❑ NO		SHADED AREAS FOR OFFICE USE ONLY

PLEASE CHANGE MY CONTRACT TO THE FOLLOWING

❑ SUBSCRIBER ONLY ❑ SUBSCRIBER & SPOUSE ❑ SUBSCRIBER & CHILD(REN) ❑ SUBSCRIBER, SPOUSE & CHILD(REN)

Change name to	EFFECTIVE DATE	LAST NAME	FIRST NAME	M.I.
Reason for name change				
Change address to	STREET ADDRESS		E-MAIL ADDRESS	
	CITY	STATE	ZIP CODE	

PLEASE ADD THE FOLLOWING DEPENDENTS TO MY CONTRACT (MUST ALSO COMPLETE OTHER SIDE)

DEPENDENT'S FULL NAME* (Include first, last, mi)	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YR	If adding maternity within 30 days of marriage, then please submit a copy of the marriage license.	DATE DEPENDENCY BEGAN
SPOUSE			❑ HUSBAND ❑ WIFE DATE OF MARRIAGE _____	
OLDEST CHILD			❑ SON ❑ STEPSON ❑ OTHER (Specify)_____ ❑ DAUGHTER ❑ STEPDAUGHTER	
CHILD			❑ SON ❑ STEPSON ❑ OTHER (Specify)_____ ❑ DAUGHTER ❑ STEPDAUGHTER	
CHILD			❑ SON ❑ STEPSON ❑ OTHER (Specify)_____ ❑ DAUGHTER ❑ STEPDAUGHTER	

***HAS ANY PERSON BEING ADDED HAD OTHER HEALTH COVERAGE WITHIN 60 DAYS? ❑ YES ❑ NO IF YOU ARE APPLYING OUTSIDE OPEN ENROLLMENT, PLEASE SUBMIT THE SPECIAL ENROLLMENT PERIOD FORM 01MK5660.**

PLEASE DROP FOLLOWING DEPENDENTS FROM MY CONTRACT

IF DROPPING THIS DEPENDENT LEAVES ONLY THE SUBSCRIBER TO BE COVERED, PLEASE CHECK THE "SUBSCRIBER ONLY" BLOCK IN THE "CHANGE MY CONTRACT" SECTION ABOVE. IT IS A DEPENDENT'S RESPONSIBILITY TO APPLY FOR CONTINUOUS COVERAGE ON A SEPARATE CONTRACT WHEN ELIGIBILITY STOPS IN ACCORDANCE WITH THE TERMS OF THE CONTRACT.

GIVE FULL NAME	EFFECTIVE DATE	CHECK RELATIONSHIP	DATE OF BIRTH MO. DAY YR	REASON
		❑ HUSBAND ❑ WIFE		
		❑ SON ❑ DAUGHTER		
		❑ SON ❑ DAUGHTER		

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.

PLEASE CHANGE MY BENEFITS TO THE FOLLOWING

SUBSCRIBER: PLEASE SIGN	SUBSCRIBER'S SIGNATURE X	DATE

OFFICE USE	EFF DATE	GROUP NO.	DEPT.	SUB	CLASS/SPEC	WAV	DEN TY	DEN CL	DEN WC	CLK CD	U.W. INT.	DT. APPRVD	RIDERS/SPEC. INFORMATION

❑ MEDICALLY UNDERWRITE	❑ OTHER	UW INITIALS	DATE

23XX0350 R03/17

SUBSCRIBER'S LAST NAME (PLEASE PRINT)	FIRST NAME	M.I.	CONTRACT NO.

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 BELOW.

SUBSCRIBER'S HEIGHT:	SUBSCRIBER'S WEIGHT:	SPOUSE'S HEIGHT:	SPOUSE'S WEIGHT:

HAS ANYONE APPLYING FOR COVERAGE EVER HAD OR BEEN DIAGNOSED WITH:	YES	NO
1) Diabetes Mellitus?	❑	❑
2) Any type of Cancer?	❑	❑
3) Any blood disorder?	❑	❑
4) A stroke (CVA)?	❑	❑
5) Circulatory problems?	❑	❑
6) Epilepsy?	❑	❑
7) Rheumatic Fever?	❑	❑
8) Abnormal blood pressure?	❑	❑
9) Heart Trouble	❑	❑
10) Tuberculosis?	❑	❑
11) Have or had lung problems?	❑	❑
12) HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC?	❑	❑
13) Hepatitis or a liver disorder?	❑	❑
IN THE LAST 5 YEARS HAS ANYONE APPLYING FOR COVERAGE HAD OR BEEN DIAGNOSED WITH:		
14) Asthma, bronchitis or chronic sinus trouble?	❑	❑
15) Allergies	❑	❑
16) Arthritis?	❑	❑
17) Rheumatism/Bursitis or Sciatica?	❑	❑
18) Had any bodily deformities?)	❑	❑
19) Had any back and/or orthopedic condition or muscular diseases, back pain or joint pain?	❑	❑
20) Had any tumors, cysts or growths?	❑	❑
21) Kidney stones or urinary system disorders, diabetes insipidus or prostate disorders?	❑	❑
22) Endocrine disorder, thyroid problem or goiter?	❑	❑
23) Hemorrhoids/rectal ailments or varicose veins?	❑	❑
24) A hernia?	❑	❑
25) Seizures, Fainting Spells?	❑	❑
26) Headaches?	❑	❑
27) Irregular/excessive menstrual bleeding?	❑	❑

	YES	NO
28) Had any female reproductive problems or female infertility?	❑	❑
29) Pelvic pain?	❑	❑
30) Gall stones or gall bladder disorder?	❑	❑
31) Abdominal pain?	❑	❑
32) Ulcers, stomach, colon or other intestinal disorders, adhesions?	❑	❑
33) Any eye conditions (excluding corrective lenses)?	❑	❑
34) Any ear condition or impairment?	❑	❑
35) A mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation?	❑	❑
36) Candidiasis (yeast infection), herpes, syphilis, gonorrhea, condylomata acuminata (genital warts), or other sexually transmitted diseases?	❑	❑
37) Alcohol or substance abuse, detoxification?	❑	❑
38) Any condition (including developmental defects or deformities) of oral cavity, jaw, facial or cranial bones, teeth and surrounding structures?	❑	❑
MISCELLANEOUS		
39) Are you expecting a biological child within the next 9 months (male or female applicant)?	❑	❑
40) Have you, or anyone on this application, used tobacco, including electronic cigarettes, in any form within the last 12 months?	❑	❑
41) Are you presently taking medications?	❑	❑
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?	❑	❑
43) Have you, or anyone on this application, ever had any health, life or disability insurance postponed, rated, ridered, declined, canceled, or had reinstatement refused?	❑	❑
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?	❑	❑

MEDICAL QUESTIONNAIRE

PLEASE GIVE THE FOLLOWING INFORMATION FOR EACH CONDITION AND ANY OTHER PERTINENT INFORMATION.

GIVE NUMBER OF QUESTION ABOVE BEING ANSWERED	NAME	ILLNESS OR CONDITION	
DATE DIAGNOSED	DATES AND TYPES OF TREATMENT (IF MEDICATION, LIST NAME OF MEDICATION AND DOSAGE)	WAS AN OPERATION RECOMMENDED? ❑ YES ❑ NO	WAS OPERATION PERFORMED? ❑ YES ❑ NO
OPERATION OR SURGICAL PROCEDURE PERFORMED OR RECOMMENDED	DATE LAST TREATED AND CURRENT CONDITION.	IF CURRENTLY ON MEDICATION, LIST NAME OF MEDICATION AND DOSAGE	

GIVE NUMBER OF QUESTION ABOVE BEING ANSWERED	NAME	ILLNESS OR CONDITION	
DATE DIAGNOSED	DATES AND TYPES OF TREATMENT (IF MEDICATION, LIST NAME OF MEDICATION AND DOSAGE)	WAS AN OPERATION RECOMMENDED? ❑ YES ❑ NO	WAS OPERATION PERFORMED? ❑ YES ❑ NO
OPERATION OR SURGICAL PROCEDURE PERFORMED OR RECOMMENDED	DATE LAST TREATED AND CURRENT CONDITION.	IF CURRENTLY ON MEDICATION, LIST NAME OF MEDICATION AND DOSAGE	

The information given herein is true and correct, to the best of my knowledge and belief. I understand that any coverage issued is based on all statements and answers to the questions contained herein. I understand that the Contract will be terminated within three years of the original effective date of the Member's (Members') coverage and all fees, less claims paid, will be refunded if an intentional misrepresentation of material fact as to that Member(s) exists in the application or any Change of Status Card. All of the above questions in the health history have been read by or to me and the answers given are provided by the applicant and/or dependent(s), if any.

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.

SUBSCRIBER: PLEASE SIGN →	SUBSCRIBER'S SIGNATURE X	DATE

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).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫູບໍ່ດີ, 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 (TTY 711)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)