



GROUP HEALTH PLAN ENROLLMENT FORM

Group # 77986

Administered by BlueCross BlueShield of Louisiana

REV. 11/2009

<b>Last Name</b>		<b>First Name</b>		<b>Middle Initial</b>		<b>Social Security Number</b>	

<b>Mailing Address</b>			<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Home Phone Number</b>

<b>Marital Status</b>		<b>Sex</b>	<b>Date of Birth</b>	<b>Date Hired Full Time</b>
<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced		<input type="checkbox"/> Male <input type="checkbox"/> Female	Month Day Year	Month Day Year

<b>Occupation</b>	<b>EE Life</b>	<b>Status</b>		
	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> New Employee <input type="checkbox"/> Retiree	<input type="checkbox"/> Rehire Date: <input type="checkbox"/> Special Enrollee	<input type="checkbox"/> Late Enrollee <input type="checkbox"/> Disabled

**CHOOSE ONE PLAN OPTION BELOW**

<b>PLAN I (Traditional Plan)</b>		<b>PLAN II (High Deductible Plan)</b>	
	<i>Premium</i>		<i>Premium</i>
Employee Only	<input type="checkbox"/> \$25.00 / Week	Employee Only	<input type="checkbox"/> \$10.00 / Week
Employee + One Dependent	<input type="checkbox"/> \$59.00 / Week	Employee + One Dependent	<input type="checkbox"/> \$35.00 / Week
Employee + Family	<input type="checkbox"/> \$86.00 / Week	Employee + Family	<input type="checkbox"/> \$50.00 / Week

**COMPLETE IF DEPENDENT COVERAGE IS REQUESTED**

Relationship	Name	Full Time Student	Date of Birth	SSN	Sex (circle one)
		<input type="checkbox"/> Yes <input type="checkbox"/> No			Male or Female
		<input type="checkbox"/> Yes <input type="checkbox"/> No			Male or Female
		<input type="checkbox"/> Yes <input type="checkbox"/> No			Male or Female
		<input type="checkbox"/> Yes <input type="checkbox"/> No			Male or Female
		<input type="checkbox"/> Yes <input type="checkbox"/> No			Male or Female

The Plan's pre-existing condition exclusion period may be reduced or eliminated by prior credible coverage.

Please provide the following information for yourself and each dependent

(A) Did any group health insurance terminate for you or your dependents within the past 62 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes to (A), attach certificate of creditable coverage for prior periods. If yes to (B), give name of policyholder, policy #, name of insured, insurance company and, if applicable, termination date.
(B) Do you or your dependents currently have other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**BENEFICIARY**

I hereby direct payment of any death benefit under the Plan to the beneficiary listed below. Unless otherwise provided, if more than one beneficiary is designated in any one class, each beneficiary in the same class shall share equally.

<b>First Name</b>	<b>Middle Initial</b>	<b>Last Name</b>	<b>Relationship</b>

**AGREEMENT**

I hereby enroll for coverage for which I am now or may become eligible under the employer sponsored group plan and hereby authorize my employer to deduct from my earnings the required contributions, if any.

<b>Signature of Employee</b>	<b>Date</b>

**WAIVER OF COVERAGE**

I have decided not to apply for coverage offered as checked below. I understand that I may not be eligible for such coverage at a later date if the Plan does not cover late enrollees. If the Plan allows open enrollment, I may be subject to a pre-existing condition exclusion period.

MEDICAL	<input type="checkbox"/> Self	<input type="checkbox"/> Dependents
LIFE	<input type="checkbox"/> Self	<input type="checkbox"/> Dependents

I decline such coverage because:

My spouse is employed by \_\_\_\_\_ and is insured for similar health benefits.

My children have health coverage under (plan or policy name) \_\_\_\_\_.

Other Reasons (explain) \_\_\_\_\_

<b>Signature of Employee</b>	<b>Date</b>

The following applies only if your group plan is subject to the Health Insurance Portability and Accountability Act of 1996

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement.