Louisiana

INDIVIDUAL CHANGE OF STATUS CARD

HMO Louisiana

AGENT'S NAME	AGENT'S NUMBER

SECTION A. SUBSCRIBER: PLEASE COMPLETE THIS SECTION (PLEASE PRINT)

LAST NAME	FIRST NAME	M.I.	CONTRACT NO.

DAYTIME PHONE NO.	ARE YOU OR ANY OF YOUR DEPENDENTS CURRENTLY RECEIVING DISABILITY/WORKERS' COMP. BENEFITS? ❑ YES ❑ NO	SHADED AREAS FOR OFFICE USE ONLY

SECTION B. 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	❑ MAILING ADDRESS ❑ PHYSICAL ADDRESS	E-MAIL ADDRESS
	CITY	STATE / ZIP CODE	DAYTIME PHONE NO.

SECTION C. PLEASE ADD THE FOLLOWING DEPENDENTS TO MY CONTRACT (MUST ALSO COMPLETE PAGE 2)

DEPENDENT'S FULL NAME*	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YR	RELATIONSHIP	Smoked in past 12 months? (including electronic)	Date Dependency Began
SPOUSE			❑ HUSBAND ❑ WIFE DATE OF MARRIAGE _____	❑ YES ❑ NO	
CHILD			❑ SON ❑ STEPSON ❑ OTHER (Specify) _____ ❑ DAUGHTER ❑ STEPDAUGHTER	❑ YES ❑ NO	
CHILD			❑ SON ❑ STEPSON ❑ OTHER (Specify) _____ ❑ DAUGHTER ❑ STEPDAUGHTER	❑ YES ❑ NO	
CHILD			❑ SON ❑ STEPSON ❑ OTHER (Specify) _____ ❑ DAUGHTER ❑ STEPDAUGHTER	❑ YES ❑ NO	

APPLIES ONLY TO NON GRANDFATHERED AFFORDABLE CARE ACT PLANS:

*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.

SECTION D. PLEASE REMOVE THE 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.

SECTION E. PLEASE CHANGE MY BENEFITS TO THE FOLLOWING

SECTION F. PLEASE TERMINATE MY CONTRACT

TERMINATION DATE

SECTION G. SUBSCRIBER: PLEASE SIGN →	SUBSCRIBER'S SIGNATURE **X**	DATE

OFFICE USE

NOTES		
EFF DATE	UW INITIALS	DATE

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 YES RESPONSE, UNDERLINE THE APPROPRIATE CONDITION IF APPLICABLE AND COMPLETE THE MEDICAL DETAILS BELOW.

SECTION H. VARIABLE INCOME PLAN (VIP) / GRANDFATHERED MEDICAL

1. Is anyone applying for coverage expecting a biological child within the next 9 months, undergoing or expecting fertility treatments, or in the process of adopting (male or female)?
   ❑ Yes ❑ No
   If Yes, please complete the Medical Details section.

2. Has anyone applying for coverage ever been advised by a physician to receive treatment, undergo a surgical operation that has not been performed or is currently hospitalized?
   ❑ Yes ❑ No
   If Yes, please complete the Medical Details section.

3. Has anyone applying for coverage ever been treated for cancer (excluding skin), blood disorder (excluding iron deficiency anemia), hemophilia, stroke (TIA), circulatory, epilepsy (seizures), organ transplant, heart trouble (excluding heart murmur), tuberculosis, lung problems (COPD/emphysema), HIV, had known exposure to AIDS or HIV, received treatment for AIDS or ARC, hepatitis B or C/liver disorder, kidney disease requiring dialysis, multiple sclerosis, Crohn's Disease, ulcerative colitis, rheumatoid arthritis, autoimmune disease (systemic lupus, scleroderma, etc), cystic fibrosis, muscular dystrophy, Parkinson's Disease, ALS (Lou Gehrig's Disease), or Gaucher Disease?
   ❑ Yes ❑ No
   If Yes, please complete the Medical Details section.

4. Height and Weight

4. Height and Weight	Subscriber's Name	Height	Weight
	Spouse's Name	Height	Weight

5. Does anyone applying for coverage take prescription drugs on a regular (daily or weekly) basis? If yes, please list drug names(s) and reason why taken below. If none taken, indicate none.
   ❑ Yes ❑ No

Applicant Name	Drug Name and Dosage	Reason
Applicant Name	Drug Name and Dosage	Reason
Applicant Name	Drug Name and Dosage	Reason
Applicant Name	Drug Name and Dosage	Reason

6. Within the last 5 years have you or anyone listed on the application received treatment, advice, medication, or surgical consultation for diabetes, hypertension (high blood pressure), high cholesterol, asthma, allergies requiring allergy injections, osteoarthritis, neurological condition, bodily deformities, back/orthopedic conditions, muscular disease, nerve disease, tumor, cyst, kidney stones, prostate disorders, endocrine disorder, hernia, migraines, irregular/excessive menstrual bleeding, breast diseases or disorders, skin cancer, abnormal papsmear, heart murmur, abdominal pain, stomach or intestinal disorders, alcohol/substance use disorder, or mental/nervous disorder (autism, eating disorder, etc.)?
   ❑ Yes ❑ No
   If Yes, please complete the Medical Details section.

7. Do you or any of your dependent applicants 18 or older use any form of tobacco including electronic cigarettes?
   Subscriber ❑ Yes ❑ No Spouse ❑ Yes ❑ No Child ❑ Yes ❑ No Child ❑ Yes ❑ No Child ❑ Yes ❑ No

SECTION I. CANCER AND SERIOUS DISEASE (CSD)

Has anyone applying for coverage ever had or presently have cancer, leukemia, encephalitis, spina,meningitis, sickle cell anemia, tetanus, diphtheria, poliomyelitis, rabies, scarlet fever, smallpox, polio, or tularemia?
❑ Yes ❑ No
If Yes, please complete the Medical Details section.

SECTION J. MEDICAL DETAILS: Please give the following information for each condition and any other pertinent information. If you run out of room, submit another 2nd page of this form with Section J Medical Details completed and Section K signed and dated.

GIVE NUMBER OF QUESTION ABOVE BEING ANSWERED	APPLICANT NAME	CONDITION
DATE DIAGNOSED	TREATMENT RENDERED (INCLUDING MEDICATION) AND DATE	
SURGERY RECOMMENDED	SURGERY PERFORMED AND DATE PERFORMED	DATE RELEASED FROM CARE

GIVE NUMBER OF QUESTION ABOVE BEING ANSWERED	APPLICANT NAME	CONDITION
DATE DIAGNOSED	TREATMENT RENDERED (INCLUDING MEDICATION) AND DATE	
SURGERY RECOMMENDED	SURGERY PERFORMED AND DATE PERFORMED	DATE RELEASED FROM CARE

GIVE NUMBER OF QUESTION ABOVE BEING ANSWERED	APPLICANT NAME	CONDITION
DATE DIAGNOSED	TREATMENT RENDERED (INCLUDING MEDICATION) AND DATE	
SURGERY RECOMMENDED	SURGERY PERFORMED AND DATE PERFORMED	DATE RELEASED FROM CARE

GIVE NUMBER OF QUESTION ABOVE BEING ANSWERED	APPLICANT NAME	CONDITION
DATE DIAGNOSED	TREATMENT RENDERED (INCLUDING MEDICATION) AND DATE	
SURGERY RECOMMENDED	SURGERY PERFORMED AND DATE PERFORMED	DATE RELEASED FROM CARE

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.

SECTION K. SUBSCRIBER: PLEASE SIGN	SUBSCRIBER'S SIGNATURE X	DATE

SECTION L. ETHNICITY RACE AND LANGUAGE (Supplying ethnicity, race, and language is voluntary, and not required.)

ENROLLEE'S FULL NAME*

Enthnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown

Race: ❑ American Indian and Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian and Other Pacific Islander ❑ Some Other Race ❑ Two or More Races ❑ White

Language: ❑ English ❑ Spanish ❑ Vietnamese ❑ Mandarin ❑ Korean ❑ Arabic ❑ Other________________

SPOUSE'S FULL NAME*

RELATIONSHIP ❑ HUSBAND ❑ WIFE

Enthnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown

Race: ❑ American Indian and Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian and Other Pacific Islander ❑ Some Other Race ❑ Two or More Races ❑ White

Language: ❑ English ❑ Spanish ❑ Vietnamese ❑ Mandarin ❑ Korean ❑ Arabic ❑ Other________________

DEPENDENT'S FULL NAME*

RELATIONSHIP ❑ SON ❑ STEPSON ❑ OTHER (Specify) ______ ❑ DAUGHTER ❑ STEPDAUGHTER

Enthnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown

Race: ❑ American Indian and Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian and Other Pacific Islander ❑ Some Other Race ❑ Two or More Races ❑ White

Language: ❑ English ❑ Spanish ❑ Vietnamese ❑ Mandarin ❑ Korean ❑ Arabic ❑ Other________________

DEPENDENT'S FULL NAME*

RELATIONSHIP ❑ SON ❑ STEPSON ❑ OTHER (Specify) ______ ❑ DAUGHTER ❑ STEPDAUGHTER

Enthnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown

Race: ❑ American Indian and Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian and Other Pacific Islander ❑ Some Other Race ❑ Two or More Races ❑ White

Language: ❑ English ❑ Spanish ❑ Vietnamese ❑ Mandarin ❑ Korean ❑ Arabic ❑ Other________________

DEPENDENT'S FULL NAME*

RELATIONSHIP ❑ SON ❑ STEPSON ❑ OTHER (Specify) ______ ❑ DAUGHTER ❑ STEPDAUGHTER

Enthnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown

Race: ❑ American Indian and Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian and Other Pacific Islander ❑ Some Other Race ❑ Two or More Races ❑ White

Language: ❑ English ❑ Spanish ❑ Vietnamese ❑ Mandarin ❑ Korean ❑ Arabic ❑ Other________________

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)