

APPLICATION FOR GROUP COVERAGE

NEW GROUP NEW SUB-GROUP DUAL CHOICE

SECTION A - COVERAGE SELECTION

Blue Cross and Blue Shield of Louisiana <input type="checkbox"/> PPO (Ded/Coins.) _____ <input type="checkbox"/> Premier Blue (Plan #) _____ <input type="checkbox"/> BlueSaver (Ded/Coins.) _____ <input type="checkbox"/> Dental (Plan #) _____ <input type="checkbox"/> TrueBlue (Ded/Coins.) _____ <input type="checkbox"/> Other (Plan #) _____	HMO Louisiana, Inc. <input type="checkbox"/> HMO (Plan #) _____ <input type="checkbox"/> POS (Plan #) _____	Southern National Life Insurance Company, Inc. <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Life Only <input type="checkbox"/> Dependent Life <input type="checkbox"/> Short Term Disability *Domestic Partnership Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Available same sex only for groups with 100 + Enrolling Contracts*

Association: Yes No: If yes: LAD 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Method of Payment		Fully Insured: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you a government plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Monthly <input type="checkbox"/> Other _____		Other Financial Arrangement:	
Are you collectively bargained? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Mental Disorders <input type="checkbox"/> Included <input type="checkbox"/> Excluded		Alcohol and Substance Abuse Services <input type="checkbox"/> Included <input type="checkbox"/> Excluded		Group Subject to: <input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation	
Pregnancy Coverage (required by federal law if 15 or more employees) <input type="checkbox"/> Included <input type="checkbox"/> 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)

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

Pre-Existing Condition Exclusion Periods

- The Standard Pre-Existing Exclusion Period applies to all BCBSLA and HMOLA fully-insured groups.
- Administrative Services Only groups may choose other options.
- The pre-existing exclusion period for mental disorders is limited to 60 days.
- 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 - ELIGIBILITY

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	Date of Hire	First billing date on or after:					Medical Product Selection	Date of Hire	First billing date on or after:				
		Date of Hire	1 Mo.	2 Mo.	3 Mo.	Other			Date of Hire	1 Mo.	2 Mo.	3 Mo.	Other
<input type="checkbox"/> Active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mgmt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Non-Mgmt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Retirees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> COBRA/State Cont.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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	Date of Hire	First billing date on or after:					Medical Product Selection	Date of Hire	First billing date on or after:				
		Date of Hire	1 Mo.	2 Mo.	3 Mo.	Other			Date of Hire	1 Mo.	2 Mo.	3 Mo.	Other
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

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
- Other* _____ Initials

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 _____