HMO Louisiana, Inc.
A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

Post Office Box 98024
Baton Rouge, Louisiana 70898-9024

LOUISIANA HMO CONTINUATION OF GROUP COVERAGE
(Under 20 Employees)

01 _____ 02 _____ 03 _____ 04 _____

THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE AND EMPLOYER AND RETURNED TO:

HMO Louisiana, Inc.
Attn: Membership and Billing Department
P.O. Box 98024
Baton Rouge, LA 70898-9024

Please have the continuing employee complete and sign this form for himself and any dependents.

EMPLOYER INFORMATION

NAME OF GROUP			GROUP POLICY NO.
ADDRESS	CITY	STATE	ZIP CODE

EMPLOYEE NAME			CONTRACT NO.
ADDRESS	CITY	STATE	ZIP CODE

EMPLOYEE'S EFFECTIVE DATE OF COVERAGE	DATE GROUP COVERAGE ENDED
NAME(S) OF CONTINUING DEPENDENTS	RELATIONSHIP OF CONTINUING PERSON(S) TO EMPLOYEE

_____ _____
EMPLOYER SIGNATURE DATE

X _____ _____
EMPLOYEE SIGNATURE DATE