

BlueChoice 65

A Medicare Supplement Program

BlueChoice 65 **SELECT**

This booklet contains three forms necessary to apply for Medicare Supplement coverage.

Upon completion of the forms, your agent will return this application booklet and your check or money order to Blue Cross and Blue Shield of Louisiana.

Attention: If the policy you are applying for is to replace your present policy, you must sign the •Notice to Applicant Regarding Replacement of Medicare Supplement Insurance• form printed at the back of this booklet. Detach the last page for your records.



APPLICATION FOR BLUE **CHOICE 65**/BLUE **CHOICE 65 SELECT** HEALTH COVERAGE

01 _____ 02 _____ 03 _____ 04 _____

OFFICE USE ONLY	CONTRACT NUMBER	CONTRACT DATE	GROUP #	MOP	TOTAL FEES	CLK.	MED. INFO ON FILE	U.W. INT. & DATE	
	REQUESTED EFF. DATE		AGENT #		PARISH	AREA CD.			
PLEASE CHECK: <input type="checkbox"/> BC 65 DISABILITY <input type="checkbox"/> BC 65 <input type="checkbox"/> BC 65 SELECT DISABILITY <input type="checkbox"/> BC 65 SELECT									
SOCIAL SECURITY NO.		LAST NAME (Print)		FIRST (Print)	MIDDLE (Print)	AC ()	PHONE NO.		
STREET ADDRESS			CITY	STATE	ZIP CODE	DO YOU WANT COMBINED BILLING? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DATE OF BIRTH	MONTH	DAY	YEAR	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	ARE YOU ENTITLED TO MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO		
EFFECTIVE DATE OF MEDICARE PART A.		MO	DAY	YR	EFFECTIVE DATE OF MEDICARE PART B.		MO	DAY	YR
YOUR MEDICARE NUMBER			ARE YOU CURRENTLY RECEIVING DISABILITY/WORKERS' COMP. BENEFITS?			<input type="checkbox"/> YES <input type="checkbox"/> NO			
METHOD OF PAYMENT: PREMIUM \$ _____ <input type="checkbox"/> MONTHLY <input type="checkbox"/> SEMI-ANNUALLY <input type="checkbox"/> QUARTERLY <input type="checkbox"/> ANNUALLY <input type="checkbox"/> BANK DRAFT									

BENEFIT DESIGN: CHECK ONE OF THE FOLLOWING PLANS

BLUECHOICE 65 PLANS: PLAN A PLAN B PLAN C PLAN F **BLUECHOICE 65 SELECT PLANS:** PLAN B PLAN C PLAN F

HEALTH HISTORY IF YES TO QUESTIONS BELOW, EXPLAIN ON REVERSE SIDE, INCLUDING MEDICATIONS AND DOSAGES.

1. Have you been advised by a physician to receive inpatient hospital treatment or undergo a surgical operation that has not been performed? YES NO
2. Are you currently a patient in a hospital, nursing home, or medical care facility? Have you been a patient in any of these facilities two or more times in the past two years? YES NO
3. Within the past two years, have you had or received treatment for internal cancer, malignant melanoma, heart condition (ex. heart attack, congestive heart failure) or circulatory system (ex. hardening of the arteries), or stroke? (Excludes high blood pressure.) YES NO
4. Have you been treated in the past two years for diabetes requiring insulin, emphysema or other obstructive lung disease, kidney disease requiring dialysis? YES NO
5. Do you take prescription drugs on a regular (daily or weekly) basis? If yes, please list drug name(s) and reason why taken. If needed, use Medical Questionnaire on back.
 DRUGS: _____ REASON: _____

Total monthly cost of prescription drugs: \$ _____

1. I, the undersigned, do hereby apply for membership in Louisiana Health Service & Indemnity Company (LHSIC), for myself. I understand that this application, any Change of Status Card and the Contract, together with any riders and endorsements issued by LHSIC constitute my contract with LHSIC. I understand the contract may be terminated within three years of the original effective date of the Member's coverage and all fees, less claims paid, will be refunded if a material misrepresentation of facts as to that Member(s) exists in the application or any Change of Status Card.
2. I understand that the coverage applied for is not part of a group health plan and that the agreement is between LHSIC and myself.
3. PROXY - I hereby constitute and appoint the directors of LHSIC, present in person or by proxy given to another director(s), to vote on my behalf at membership meetings on any matters on which policyholders are entitled to vote. **I acknowledge notice 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 I revoke my proxy, I may continue to pay my premium without affecting the revocation or my coverage. I understand that I may designate any other policyholder as my proxy by sending any form of writing to Louisiana Health Service & Indemnity Company at P. O. Box 98029, Baton Rouge, Louisiana 70898. **Check this block if you do not want to grant your proxy.**
4. I understand that this is an application for coverage and is not binding on LHSIC. I understand that LHSIC reserves the right to set the effective date for any Contract issued and that the Contract will not become effective until that date is established by LHSIC.
5. I acknowledge that I have received both an outline of Medicare Supplement coverage and a "Guide to Health Insurance for People with Medicare."
6. If choosing BlueChoice 65 SELECT, I acknowledge that I have received a listing of network hospitals participating in the BlueChoice 65 SELECT program and disclosure information on the BlueChoice 65 SELECT program.
7. I understand that BlueChoice 65 SELECT plan benefits will not be provided for the Part A Medicare deductibles and coinsurance when hospitalized in a non-network hospital, except in the case of emergencies.

IMPORTANT! Please 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 on page 3. 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 used or disclosed in connection with future underwriting or renewal efforts.

Your Height: _____ Your Weight: _____ Spouse's Height: _____ Spouse's Weight: _____

HAS ANYONE APPLYING FOR COVERAGE EVER HAD OR BEEN DIAGNOSED WITH:

1. Diabetes Mellitus? Yes No
2. Any type of Cancer? Yes No
3. Any blood disorder? Yes No
4. A stroke (CVA)? Yes No
5. Circulatory problems? Yes No
6. Epilepsy? Yes No
7. Rheumatic Fever? Yes No
8. Abnormal blood pressure? Yes No
9. Heart Trouble? Yes No
10. Diagnosed with Tuberculosis? Yes No
11. Had or have other lung problems? Yes No
12. Tested positively for HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC? Yes No
13. Either Hepatitis or a liver disorder? Yes No

IN THE LAST 5 YEARS HAS ANYONE APPLYING FOR COVERAGE:

14. Been diagnosed with asthma, bronchitis or chronic sinus trouble? Yes No
15. Been diagnosed with allergies? Yes No
16. Been treated for arthritis? Yes No
17. Been treated for Rheumatism/Bursitis or Sciatica? Yes No
18. Had any bodily deformities? Yes No
19. Had any back/orthopedic condition or muscular diseases? Yes No
20. Had any known tumors or cysts? Yes No
21. Been treated for kidney stones or urinary system disorders, diabetes insipidus or prostate disorders? Yes No
22. Been diagnosed with an endocrine disorder, thyroid problem or goiter? Yes No
23. Been treated for hemorrhoids/rectal ailments or varicose veins? Yes No
24. Had a hernia? Yes No
25. Had seizures, fainting spells? Yes No
26. Had headaches? Yes No
27. Had irregular/excessive menstrual bleeding? Yes No
28. Had any other female reproductive problems? Yes No
29. Had pelvic pain? Yes No
30. Had gall stones or gall bladder disorder? Yes No
31. Had abdominal pain? Yes No
32. Had ulcers, stomach, colon or other intestinal disorders, adhesions? Yes No
33. Had any eye conditions (excluding corrective lenses)? Yes No
34. Had any ear condition or impairment? Yes No
35. Had a mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation? Yes No
36. Had candidiasis (yeast infection), herpes, syphilis, gonorrhea, condylomata acuminata (genital warts), or other sexually transmitted diseases? Yes No
37. Suffered from or received treatment for alcohol or substance abuse, detoxification? Yes No
38. Had any condition (including developmental defects or deformities) of oral cavity, jaw, facial or cranial bones, teeth and surrounding structures? Yes No

MISCELLANEOUS

39. Are you expecting a biological child within the next 9 months (male or female applicant)? Yes No
40. Have you, or anyone on this application, used tobacco in any form within the last 12 months? Yes No
41. Are you presently taking medications for conditions not mentioned in other questions? (please list medications) Yes No
42. Are you, or anyone on this application, engaged in private flying, parachuting, hang gliding, racing, underwater diving, handling of explosive materials, hazardous wastes or materials? Yes No
43. Have you, or anyone on this application, ever had any health insurance postponed, rated, ridered, declined, canceled, or had reinstatement refused? Yes No
44. Any departure from good health or any medical or surgical advice or treatment from any medical practitioner (medical doctor/surgeon, podiatrist, optometrist, chiropractor, dentists/oral surgeons, etc.) in the last 5 years? Yes No

Instructions:

- Carefully read the Statements in Section 1.
- Answer the questions in Section 2 to the best of your knowledge.
- Sign the form.
- Agent must complete Section 3 and sign.

SECTION 1**Statements**

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

SECTION 2**Questions (To Be Answered By Applicant)**

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. [Please mark Yes or No below with an "X"]

To the best of your knowledge,

- 1.(a) Did you turn 65 in the last 6 months? Yes No
(b) Did you enroll in Medicare Part B in the last 6 months Yes No
(c) If yes, what is the effective date? _____
2. Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are a participant in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes No

If yes,

- (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes No
- (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No
3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START ___/___/___ END ___/___/___
- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No
- (c) Was this your first time in this type of Medicare plan Yes No
- (d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No
4. (a) Do you have another Medicare supplement policy in force? Yes No
- (b) If so, with what company, and what plan do you have? _____
- (c) If so, do you intend to replace your current Medicare supplement policy with this policy Yes No
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) Yes No
- (a) If so, with what company and what kind of policy? _____

- (b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.) START ___/___/___ END ___/___/___

SECTION 3

Agent Must Complete This Section

Agents shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five (5) years which are no longer in force.

Applicant's Name (Print)

Agent/Broker's Signature

Date

X

Applicant's Signature

Date



**BlueCross BlueShield
of Louisiana**

An independent licensee of the Blue Cross and
Blue Shield Association.

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE**

Blue Cross and Blue Shield of Louisiana* • P. O. Box 98029 • Baton Rouge, LA 70898-9029

Instructions:

- **This form (and copy on opposite page) should be completed only if you plan to replace your existing Medicare supplement policy. Your agent will fill in the information required.**
- **After your agent completes the form, sign it at the bottom.**
- **Detach copy for your records.**

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Blue Cross and Blue Shield of Louisiana. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT, BROKER OR AUTHORIZED REPRESENTATIVE

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage, or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits
 - No change in benefits, but lower premiums
 - Fewer benefits and lower premiums
 - My plan has outpatient prescription drug coverage and I am enrolling in Part D
 - Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment
- _____
- Other: (Please specify) _____
- _____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

Signature of Agent, Broker, or other Representative

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, LA 70898-9029

Date

Applicant's Name (Print)

X

Applicant's Signature

Date

COMPANY COPY

23XX2472 R01/06

*An independent licensee of the Blue Cross and Blue Shield Association.

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company

**APPOINTMENT OF REPRESENTATIVE TO SUBMIT AN ELECTRONIC DOCUMENT
AND SIGNATURE FOR INSURANCE COVERAGE**

_____ (hereinafter “Applicant”) does hereby appoint _____
(Producer/Group Leader) to act as his/her representative (hereinafter “Representative”) for the express purpose of submitting certain written personal information provided by Applicant to Louisiana Health Service and Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana and its subsidiaries (“BCBSLA”) in an electronic format as part of the process of applying for and/or maintaining insurance coverage.

The Applicant hereby appoints the Representative to translate/convert all personal information received from Applicant in a written Document for Insurance Coverage (hereinafter “Document”) into an electronic format. The personal information submitted by Representative shall be taken from the paper Document after the Applicant reads and accurately completes the Document in its entirety and signs the Document. The Representative shall correctly, accurately and completely transmit/convert all of the information provided by Applicant on the Document in an electronic format to BCBSLA.

“Document” shall include all insurance forms provided by BCBSLA that are completed and signed by Applicant including, but not limited to the Application Form, Enrollment Form, Prior Carrier Form, Dependent Certification Form, and the COBRA form.

As part of this process of applying for insurance coverage with BCBSLA, Applicant has provided Representative with unique personal data that will be used to create a personal electronic signature. Representative shall further be granted permission to use Applicant’s electronic signature to authenticate and verify that he/she is the Representative of Applicant and that the information provided electronically to BCBSLA is, to the best of his/her knowledge, correct, accurate, and complete. Upon request, the Representative shall make a copy of the executed authorization form and paper application available to Applicant.

Applicant agrees that Representative’s use of Applicant’s electronic signature shall constitute Applicant’s authorization and shall be considered as Applicant’s legally binding signature for all of the appropriate Insurance Documents and forms submitted electronically to BCBSLA. Applicant shall have ten (10) days after receipt of a copy of the electronic Document(s) to notify BCBSLA that information on the Document(s) is not accurate. If notice is not received within the appropriate time frame, then the electronic Document(s) transmitted to BCBSLA by the Representative shall be considered an accurate and original Document(s) authorized and completed by Applicant.

Signatures:

Applicant

Date

Producer/Group Leader as
Representative
for Applicant

Date



BlueCross BlueShield
of Louisiana

A B C B S A



HMO
Louisiana, Inc.

A subsidiary of Blue Cross and Blue Shield of Louisiana,
Independent licensees of the Blue Cross and Blue Shield Association

PRIOR CARRIER HEALTH COVERAGE FORM

P

T

INSTRUCTIONS

Section 1: Personal Information- P

B C B S L M O L I

Section 2a: Prior Carrier Information- P

I

NOT

S

must

prior carrier's coverage. If you have not yet terminated the other coverage, please

Section 2b: Member Information- P

T

Section 3: Certification by Subscriber- P

T

CONTRACT NO

SECTION 1: PERSONAL INFORMATION

NAME		SOCIAL SECURITY NUMBER	
P ONE NUMBER	CURRENT GROUP NUMBER IF APPLICABLE		

SECTION 2A: PRIOR CARRIER INFORMATION

PRIOR CARRIER NAME AND ADDRESS

PRIOR CARRIER P ONE NUMBER

TYPE OF POLICY LIMITED BENEFITS C S D V I P D
 COMPREHENSIVE

SECTION 2B: PRIOR CARRIER MEMBER INFORMATION

NAME	SE MF	RELATIONS IP TO CONTRACT OLDER	EFFECTIVE DATE HEALTH MO DA R	TERMINATION DATE HEALTH MO DA R	EFFECTIVE DATE DENTAL MO DA R	TERMINATION DATE DENTAL MO DA R
SUBSCRIBER						
SPOUSE						
DEPENDENT						
DEPENDENT						
DEPENDENT						

FRAUD STATEMENT A

SIGNATURE X DATE _____

SECTION 3: CERTIFICATION BY SUBSCRIBER

I attest that the information given on this form is accurate and true to my knowledge, and that I will refund immediately any monies paid in error by Blue Cross and Blue Shield of Louisiana as a result of misrepresented information on this form.

_____ DATE X _____ SUBSCRIBER'S SIGNATURE

R B C B S L L S I C



3445 N Causeway, Ste 605
Metairie, LA 70002
Phone: (504) 837-0110
Fax: (504) 828-9395

Blue Cross Blue Shield Individual Payment Options

Affordable Health Plans submits Blue Cross applications online via a Secure Server to Blue Cross. This expedites application processing by as much as two weeks. Please choose your method of initial payment below. Please note that the tender types are rated for time factors. Unless you select monthly bankdraft, your subsequent bills will be received in the mail.

Choose your initial payment type:

Initial Bankdraft: Submit a voided check along with your application. The initial premium amount will be bankdrafted on your effective date if you are approved. You will receive a monthly bill for subsequent payments. ***Use this method for faster processing.***

Initial Credit Card Payment: To have your initial premium charged to your credit card, please complete the information below. Your initial premium will be charged on your effective date if you are approved. You will receive a monthly bill for subsequent payments. ***Use this method for faster processing.***

Type of Card: (Please Circle) Visa or Mastercard Only

Card #: _____ Expiration Date: _____

I authorize Blue Cross to charge my credit card for the initial premium if approved.

Signature: _____ Date: _____

Monthly BankDraft: Submit a voided check along with your application. The initial premium amount will be bankdrafted on your effective date if you are approved. Subsequent payments will also be bankdrafted on the 1st or 15th of each month. ***Use this method for faster processing.***

Check or Money Order: Submit a check or money order for your initial premium. You will receive a monthly bill for subsequent payments. ***This method can add 1-2 weeks to your processing time.***

Name: _____ Social Security Number: _____

Signature: _____ Date: _____



Please detach the application and give the notices on the following pages to the applicant.



BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross
and Blue Shield Association.

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE**

Blue Cross and Blue Shield of Louisiana* • P. O. Box 98029 • Baton Rouge, LA 70898-9029

Instructions:

- **This form (and copy on opposite page) should be completed only if you plan to replace your existing Medicare supplement policy. Your agent will fill in the information required.**
- **After your agent completes the form, sign it at the bottom.**
- **Detach copy for your records.**

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Blue Cross and Blue Shield of Louisiana. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT, BROKER OR AUTHORIZED REPRESENTATIVE

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage, or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits
 - No change in benefits, but lower premiums
 - Fewer benefits and lower premiums
 - My plan has outpatient prescription drug coverage and I am enrolling in Part D
 - Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment
- _____
- Other: (Please specify) _____
- _____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

Signature of Agent, Broker, or other Representative

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, LA 70898-9029

Date

Applicant's Name (Print)

X

Applicant's Signature

Date

APPLICANT RETAINS THIS COPY

23XX2472 R01/06

*An independent licensee of the Blue Cross and Blue Shield Association.

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company



**CUSTOMER NOTICE OF OUR
INFORMATION PRIVACY POLICIES AND PRACTICES**
Information Only – No Response Necessary

Effective Date: July 1, 2001

Blue Cross and Blue Shield of Louisiana knows that our customers expect privacy and security regarding all of their personal and financial information. It is important to us that we protect the privacy and security of your information.

This notice will tell you about how we collect, use, secure, and share your personal information, which is information about you that identifies you and that we obtain from you and others when we provide insurance products and services to you. We will inform you of our policies for collecting, using, securing and sharing nonpublic personal financial information the first time we do business with you and every year that you are our customer.

What Information We Collect and From Whom We Collect It

We collect personal information about you that includes your name, address, Social Security number, health, and financial information. This information is obtained from the forms you fill out, from telephone or person-to-person interviews with you, and from your agent. We also obtain your personal information through claims documents, payment history and other records available to us to determine which products and services are appropriate for you. We may also receive personal information about you from our affiliates and other companies.

What Information We Share and With Whom We Share It

We may share your information, even after you are no longer our customer, with our affiliates as well as companies we do business with. We only share your information that we are allowed to by law. For example, we may share your information with persons, such as your agent, or companies who perform marketing or other services for us related to the products and services we provide you. We may also share your information with other financial institutions with which we have joint marketing agreements to provide our products and services.

How We Protect Information

Within our company, only our employees who need to know about your information in order to provide our products and services to you are allowed to have access to your information. We keep your information safe and secure so that unauthorized individuals do not have access to it. We maintain physical, electronic, and procedural safeguards that comply with legal requirements to protect your information.

This notice has been sent to you in response to the Gramm-Leach-Bliley legislation. For a more comprehensive Notice regarding our Company's privacy practices and policies, please read the "Notice of Privacy Practices Regarding Medical Information" located on our website www.bcbsla.com or call the Privacy Office at (225) 298-1751 to obtain a copy.

01MK1952 R03/04



**BlueCross BlueShield
of Louisiana**

An independent licensee of the Blue Cross
and Blue Shield Association.



**HMO
Louisiana, Inc.**

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

SUMMARY OF PRIVACY PRACTICES NOTICE

Blue Cross and Blue Shield of Louisiana and its affiliate, HMO Louisiana, Inc., believe that privacy and confidentiality regarding personal medical information is important to every customer. And securely protecting our customers' privacy is a responsibility we take very seriously.

We want you to know there is now a federal regulation that governs the privacy of your medical information and how we use and share that information in the course of our regular business activities. This federal regulation requires us to provide you with a detailed description – or "Notice" – of how we use your medical information.

The attached Notice goes into detail on how we may use and share your medical information in the course of treatment, payment and health care (business) operations. In general, unless it is described in the accompanying Notice, we will **not** use or disclose your medical information **without** your written authorization. For example, we may use and disclose your medical information to:

- Enroll you in our plan
- Determine your eligibility for benefits
- Pay your claims
- Underwrite your contract / certificate of coverage
- Audit our business practices
- Conduct medical reviews
- Conduct quality improvement activities
- Bill you or your employer for your premiums
- Develop strategic business plans

Your information may be shared with the physicians or other providers who treat you, with other insurance companies, with your employer (following specific guidelines), or with a company we hire to help us do our work. We may also disclose your medical information to your family members, friends and others you choose to involve in your health care or in the payment of your health care.

Although this occurs rarely, we may also use and disclose your medical information when required by law for various public interest activities, including regulatory oversight of our company (by the Department of Insurance, for example), law enforcement, disaster relief, and certain other public benefit functions.

The federal privacy rules also give you certain rights. Please review this entire Notice to learn about your rights and how to put them to use for you, as well as the procedure to voice complaints regarding our privacy practices.

Maintaining your trust and confidence is our highest priority, and we value your business. Thank you for being our customer.

BLUE CROSS AND BLUE SHIELD OF LOUISIANA & HMO LOUISIANA, INC.
NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and send the new Notice to our health plan subscribers at the time of the change.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this Notice.

Uses and Disclosures of Medical Information

We will refer to your "health information" throughout this Notice. When we say "Health Information," we mean what the federal privacy rules ("the HIPAA privacy regulations") call "Protected Health Information." This is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; (iii) the past, present, or future payment for the provision of health care to you. Any terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Regulations as set out in 45 C.F.R. § 164.501.

REQUIRED DISCLOSURES OF YOUR HEALTH INFORMATION

We **must** disclose your health information:

- To you or someone who has the legal right to act for you (your personal representative), if the information you seek is contained in a designated record set, and
 - The Secretary of the Department of Health and Human Services, if necessary, to investigate or determine our compliance with the HIPAA Privacy Regulations.
-

PERMISSIVE DISCLOSURES OF YOUR HEALTH INFORMATION

We **have the right** to use and disclose your health information for:

Treatment: We may disclose your health information to a physician or other health care provider to treat you. For example, we may send a copy of a member's medical records we maintain to a physician who needs the additional information to treat the member.

Payment: We may use and disclose your health information to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits, and the like. We may disclose your health information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your health information for health care operations. Health care operations include:

- reviewing and evaluating health care provider and health plan performance, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- health care quality assessment and improvement activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage; and
- business planning, development, management, and general administration, including customer service, grievance resolution, de-identifying health information, and creating limited data sets for health care operations, public health activities, and research.

For a full list of the activities covered by the terms in this section please consult the definitions set out in 45 C.F.R. § 164.501.

Others Covered by the Privacy Rule: We may disclose your health information to another health plan or to a health care provider for certain health care operations subject to federal privacy protection laws. We may do so as long as the plan or provider has or had a relationship with you and the health information is for that plan's or provider's health care quality assessment and improvement activities, evaluation, or fraud and abuse detection and prevention. For example, we may share your information with your doctors for their licensing or credentialing activities.

Business Associates: We hire individuals and companies to perform various functions on our behalf or to provide certain types of services for us. In order to help us, these business associates may receive, create, maintain, use, or disclose your health information. Before they may have any contact with your health information, we require them to sign a written agreement stating they will keep your health information private and secure.

Examples of our business associates include:

- Medical experts hired to review claims
- A pharmacy benefits management company hired to assist us in managing pharmacy claims.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. However, we will not be able to undo any action that was taken before that authorization was revoked. Unless you give us a written authorization, we will not use or disclose your health information for any purpose other than those described in this Notice.

Family, Friends, and Others Involved in Your Care or Payment for Care: Unless you object, we may disclose your health information to a family member, friend or any other person you involve in your health care or payment for your health care. We will disclose only the health information that is related to the person's involvement. We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in appropriate situations, such as medical emergency or during disaster relief efforts. (For example, to Red Cross during a natural disaster.) Before we make such a disclosure, we will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing your health information is in your best interest under the circumstances.

Your Employer: We may disclose to your employer whether or not you are enrolled in a health plan that your employer sponsors. We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan. Summary health information is information about claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although this summary health information does not specifically identify any individual, it still may be possible to identify you or others through review of this summary health information.

We may disclose your health information and the health information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must meet certain requirements. This includes amending the plan document for your group health plan to establish the limited uses and disclosures it may make of your health information. Please see your group health plan document for a full explanation of the limitations placed on your employer for the use of this information and for any disclosures that may be made to the group health plan itself.

Health-Related Products and Services : We may use your health information to communicate with you about health-related products, benefits and services and payment for those products, benefits and services that we provide or include in our benefits plan, and about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in our network, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to, although they are not part of, our benefits plan. For example, we may contact you about a Medicare Supplemental policy when you near age 65.

Public Health and Benefit Activities: Although this does not occur often, we may use and disclose your health information when required by law and when authorized by law for the following kinds of public interest activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention enforcement agencies;
- for research in certain situations, such as when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Individual Rights

The following are your rights with respect to your health information. If you would like to exercise any of the following rights, please submit your request in writing, sign your request, and mail it to the Blue Cross and Blue Shield of Louisiana Privacy Office at P.O. Box 84656, Baton Rouge, LA 70884-4656. Our contact information is provided at the end of this Notice.

Access: You have the right to examine and to receive a copy of your health information we maintain about you in a "designated record set," with limited exceptions. You are not entitled to inspect and/or copy:

- any psychotherapy notes;
- any information compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding;
- any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a); or
- certain other records as specified in the HIPAA Privacy Regulation.

Generally, a “designated record set” contains:

- claims and payment information;
- enrollment and billing information;
- other records used to make decisions about your health care benefits.

We may charge you reasonable, cost-based fees for a copy of your health information, for mailing the copy to you, and for preparing any summary or explanation of your health information you may request. Contact us using the information at the end of this Notice for information about our fees. You may withdraw your request if you do not wish to pay the fees.

In certain situations we may deny your request to inspect and obtain a copy of your health information. If we deny your request, we will notify you in writing and will inform you whether or not you have the right to have the denial reviewed.

Disclosure Accounting: You have the right to an accounting of certain disclosures that we make of your health information after April 13, 2003, excluding disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities.

We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than six years before the date of your request and never for a disclosure that occurred before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. Contact us using the information at the end of this Notice for information about our fees.

Amendment: You have the right to request that we amend your health information that we maintain about you in your designated record set. We may deny your request for certain reasons. For example, we may deny your request if the information you want to amend was created by your doctor. If we deny your request, we will provide you a written explanation, and explain to you how you can disagree with the denial by filing a statement of disagreement with us. If we accept your request, we will make your amendment part of your designated record set, and use reasonable efforts to inform others of the amendment who we know may have relied on the unamended information to your detriment, as well as persons you tell us you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your health information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will honor our agreement, except in a medical emergency or as required or authorized by law. Any agreement we may make to a request for restriction must be in writing and agreed to by our Privacy Office.

Confidential Communication: If you believe that a disclosure of all or part of your health information may endanger you if sent to your current mailing address, you have the right to request that we communicate with you in confidence about your health information by a different means or to a different location that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.

We will accommodate your request if it is reasonable. You must specify the alternative means of contact or location for

confidential communication, and continue to permit us to collect premiums and pay claims under your health plan. Please note that other information that we send to the subscriber about health care benefits received may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence. If you have given someone else permission to receive health information about you, a request for confidential communications will cancel this permission unless you tell us otherwise.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you have the right to receive this Notice in written form. Please contact us using the information at the end of this Notice to obtain this Notice in written form.

Potential Impact of State Privacy Laws: The federal health care Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, or disclosure of health information of minors.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this Notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your health information, you may complain to us using the contact information at the end of this Notice. You also may submit a written complaint to the Secretary of the United States Department of Health and Human Services. We will provide you with the address to file your complaint with the United States Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

By mail:
Privacy Office
Blue Cross and Blue Shield of Louisiana
P.O. Box 84656
Baton Rouge, LA 70884-4656

Telephone: (225) 298-1751
Fax: (225) 295-2599

E-mail: Privacy.Office@BCBSLA.com
(Individual Rights requests will not be accepted via e-mail.)



YOUR RIGHTS REGARDING THE RELEASE OF GENETIC INFORMATION

Blue Cross and Blue Shield of Louisiana, shall not, solely on the basis of any genetic information concerning an individual or family member or solely on the basis of an individual's or family member's request for or receipt of genetic services, or refusal to submit to a genetic test or make available the results of a genetic test:

- (1) Terminate, restrict, limit or apply conditions to the coverage provided under the policy or plan, or restrict the sale of the policy or plan to an individual or family member;
- (2) Cancel or refuse to renew the coverage of an individual or family member under the policy or plan;
- (3) Deny coverage or exclude an individual or family member from coverage under the policy or plan;
- (4) Impose a rider that excludes coverage for certain benefits or services under the policy or plan;
- (5) Establish differentials in premium rates or cost-sharing for coverage under the policy or plan; or
- (6) Otherwise discriminate against an individual or family members in the provision of insurance.

Blue Cross and Blue Shield of Louisiana is prohibited by law from requiring any applicant or subscriber to undergo genetic testing or to be subjected to questions relating to genetic information.

As provided by law, "genetic information" means all information about genes, gene products, inherited characteristics, or family history/pedigree as expressed in common language.

GUARANTEED RENEWABLE

This contract is automatically guaranteed renewable, subject to all the terms and provisions of the Contract, upon payment of fees when due. If approved, no pre-existing or probationary periods are part of this Contract.

LIMITATIONS AND EXCLUSIONS

Benefits will not be provided for charges covered by or available under the provisions of Medicare.

For Customer Service call:
1-800-258-3365.

RECEIPT

BlueChoice 65: Plan A Plan B Plan C
 Plan F
 Disability (Please mark plan above)

BlueChoice 65 SELECT: Plan B Plan C Plan F
 Disability (Please mark plan above)

Make check payable to:
Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, Louisiana 70898-9029

Date _____ 20 _____

Received of: _____

\$ _____ dollars for
_____ month s initial premium for:

Agent/Broker



**BlueCross BlueShield
of Louisiana**

An independent licensee of the Blue Cross
and Blue Shield Association.