



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

Individual Application Instructions for Submission

1. Fill in the entire application.
If the application is for coverage of a minor only, please list the minor as the applicant. However, a parent or legal guardian must sign the application on behalf of the minor.
2. Fill in the Prior Carrier form if you have had coverage within the last 63 days. Account for at least the last 12 months of coverage.
3. Choose how you would like to pay your initial premium. If you choose initial or monthly bankdraft, please be sure to send a copy of a voided check.
 - a. If you are paying by bankdraft or credit card draft, please fax your application to (504) 828-9395 or scan and email to service@affordablehealthplans.net
 - b. If you are paying by check or money order, please mail the payment and application to:
Affordable Health Plans
3445 N Causeway Ste 605
Metairie, LA 70002

The underwriting process usually takes 7-10 business days, but may take longer if additional information (such as medical records) is needed. We will keep you updated on the progress of your application!

Should you have any questions, please do not hesitate to call us at (504) 837-0110.

LOUISIANA BLUE HEALTH PLANS APPLICATION FOR INDIVIDUAL HMO/POS HEALTH COVERAGE

01 _____ 02 _____ 03 _____ 04 _____

OFFICE USE ONLY	CONTRACT NUMBER		CONTRACT DATE		GROUP NUMBER		MOP	WC	CLASS	CONTROL NUMBER	PARISH
	ENROLL	RATE CODE	TOTAL FEES		CONVERSION DATE		U.W. INT.	DATE	CLERK	MED. INFO. ON FILE	AREA CD.
										REQUESTED EFF. DATE	AGENT#

LIST BILL: YES, COMPANY NAME AND NUMBER

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 <input type="checkbox"/> OTHER	OCCUPATION		

COMPLETE THIS SECTION ONLY IF DEPENDENTS ARE TO BE COVERED

DEPENDENT'S FULL NAME (Include first, last, mi)	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO DAY YR	IF DEPENDENT CHILD IS OVER 20, INDICATE IF FULL-TIME STUDENT. IF DEPENDENT IS NOT NATURAL CHILD, ATTACH CERTIFIED DOCUMENTATION OF LEGAL CUSTODY OR ADOPTION.	FULL-TIME STUDENT	DEPENDS UPON YOU FOR SUPPORT?	DATE DEPENDENCY BEGAN	RESIDES WITH YOU?
SPOUSE			<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEPDAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

OUT OF AREA DEPENDENT(S) NAME(S) AND (CITY AND STATE): _____

For dependents residing out of the subscriber's Louisiana Blue Health Plans Service Area and who would like to be covered under Dependent Out-of-Area Benefits, please complete an HMO Louisiana Dependent Certification form (04100 00066) available from your agent or by calling 1-800-376-7741 and submit with this application.

METHOD OF PAYMENT (List Bill Must Be Monthly) <input type="checkbox"/> MONTHLY <input type="checkbox"/> SEMI-ANNUALLY <input type="checkbox"/> QUARTERLY <input type="checkbox"/> ANNUALLY <input type="checkbox"/> BANK DRAFT	DO YOU OR YOUR DEPENDENTS HAVE, OR HAD WITHIN 63 DAYS, OTHER HEALTH INSURANCE INCLUDING MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE CONTRACT NUMBER AND PLAN NAME: _____ IF COVERAGE WITHIN 63 DAYS (PORTABILITY), COMPLETE FORM 01100 00040. HAVE YOU/DEPENDENT EVER HAD BLUE CROSS AND BLUE SHIELD COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO POLICYHOLDER NAME _____ POLICY NUMBER _____
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BENEFIT DESIGN: CHECK CLASS AND COMPLETE ONE OF THE FOLLOWING PLANS

CLASS (CHECK ONE)	<input type="checkbox"/> APPLICANT ONLY	<input type="checkbox"/> APPLICANT AND SPOUSE	<input type="checkbox"/> APPLICANT AND ELIGIBLE CHILDREN	<input type="checkbox"/> APPLICANT AND SPOUSE AND ELIGIBLE CHILDREN (FAMILY)
HMO/POS				
<input type="checkbox"/> PLAN 1 \$20 COPAY	<input type="checkbox"/> PLAN 2 \$25 COPAY	<input type="checkbox"/> PLAN 3 \$30 COPAY	<input type="checkbox"/> PLAN 4 \$35 COPAY (\$500 Pharm. Ded.)	
HAVE YOU USED TOBACCO IN ANY FORM WITHIN THE LAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO				
HAS YOUR SPOUSE USED TOBACCO IN ANY FORM WITHIN THE LAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO				
RISK LEVEL: <input type="checkbox"/> PREFERRED <input type="checkbox"/> STANDARD 1 <input type="checkbox"/> STANDARD 2 <input type="checkbox"/> STANDARD 3				

SUBMITTED WITH APPLICATION: \$ _____ PERSONAL CHECK \$ _____ MONEY ORDER
 \$ _____ OTHER, EXPLAIN _____

1. I, the undersigned, do hereby apply for membership in HMO Louisiana, Inc. (HMOLA), for myself and my dependents, if any, listed on this application. If the application is accepted, a contract will be issued. I understand that this application, any Change of Status Card and Contract, together with any riders and endorsements issued by HMOLA constitute my contract with HMOLA. I understand the contract as it pertains to me and my dependents may be terminated within three years of the original effective date of coverage and all fees, less claims paid, will be refunded if a material misrepresentation of fact exists in the application or any Change of Status Card.

2. The information given herein is true and correct, to the best of my knowledge and belief.

NOTICE - YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN, WHEN REQUIRED.

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 HMO Louisiana Inc. in connection with this application may be retained by HMO Louisiana Inc. 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:

- 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. Been diagnosed with Rheumatic Fever? Yes No
- 8. Been diagnosed with abnormal blood pressure? Yes No
- 9. Heart Trouble? Yes No
- 10. Been 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. Been diagnosed with either Hepatitis or a liver disorder? Yes No

HAS ANYONE APPLYING FOR COVERAGE HAD IN THE LAST 5 YEARS:

- 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? 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

PROVIDE DETAILS ACCORDING TO THE MEDICAL QUESTIONNAIRE GUIDE

<p>Question Number: _____</p> <p>Person: _____</p> <p>Condition: _____</p> <p>Comments:</p>	<p>a. _____</p> <p>b. _____</p> <p>c. _____</p> <p>d. _____</p> <p>e. _____</p> <p>f. _____</p> <p>g. _____</p>
<p>Question Number: _____</p> <p>Person: _____</p> <p>Condition: _____</p> <p>Comments:</p>	<p>a. _____</p> <p>b. _____</p> <p>c. _____</p> <p>d. _____</p> <p>e. _____</p> <p>f. _____</p> <p>g. _____</p>
<p>Question Number: _____</p> <p>Person: _____</p> <p>Condition: _____</p> <p>Comments:</p>	<p>a. _____</p> <p>b. _____</p> <p>c. _____</p> <p>d. _____</p> <p>e. _____</p> <p>f. _____</p> <p>g. _____</p>
<p>Question Number: _____</p> <p>Person: _____</p> <p>Condition: _____</p> <p>Comments:</p>	<p>a. _____</p> <p>b. _____</p> <p>c. _____</p> <p>d. _____</p> <p>e. _____</p> <p>f. _____</p> <p>g. _____</p>

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.

<p>I have personally obtained the information shown on this application.</p> <p>_____ Producer's Signature Date</p> <p>_____ Print Name Phone No.</p> <p>_____ Producer's E-Mail Address</p> <p>Met with applicant in person: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Physical Requested: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>All of the questions in the health history section have been read by or to me and the answers given are provided by the applicant and/or dependent(s) if any.</p> <p>_____ Applicant's Signature Date</p> <p>_____ Print Name (Applicant) E-Mail Address</p> <p>_____ Relationship to Applicant</p>
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**SUPPLEMENTAL APPLICATION
FOR LOUISIANA BLUE HEALTH PLANS
PHYSICIAN SELECTION AND CHANGE FORM**

USE THIS SECTION TO SELECT A PRIMARY CARE PHYSICIAN.

SUBSCRIBER S CONTRACT NUMBER

SUBSCRIBER	ARE YOU AN ESTABLISHED PATIENT OF THE PCP YOU ARE SELECTING? <input type="checkbox"/> YES <input type="checkbox"/> NO		
SUBSCRIBER S NAME			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PHYSICIAN S NAME	PROVIDER NUMBER	EFFECTIVE DATE	
PHYSICIAN S ADDRESS			

SPOUSE	ARE YOU AN ESTABLISHED PATIENT OF THE PCP YOU ARE SELECTING? <input type="checkbox"/> YES <input type="checkbox"/> NO		
SPOUSE S NAME			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PHYSICIAN S NAME	PROVIDER NUMBER	EFFECTIVE DATE	
PHYSICIAN S ADDRESS			

DEPENDENT	ARE YOU AN ESTABLISHED PATIENT OF THE PCP YOU ARE SELECTING? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DEPENDENT S NAME			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PHYSICIAN S NAME	PROVIDER NUMBER	EFFECTIVE DATE	
PHYSICIAN S ADDRESS			

DEPENDENT	ARE YOU AN ESTABLISHED PATIENT OF THE PCP YOU ARE SELECTING? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DEPENDENT S NAME			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PHYSICIAN S NAME	PROVIDER NUMBER	EFFECTIVE DATE	
PHYSICIAN S ADDRESS			

DEPENDENT	ARE YOU AN ESTABLISHED PATIENT OF THE PCP YOU ARE SELECTING? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DEPENDENT S NAME			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PHYSICIAN S NAME	PROVIDER NUMBER	EFFECTIVE DATE	
PHYSICIAN S ADDRESS			

Please list any other dependents on the reverse side of this form including the above requested information.

X _____
SIGNATURE

DATE



3445 N Causeway, Ste 605
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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: _____

