



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.

J1 _____ 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 #

PLEASE CHECK: BLUE MAX BLUE SELECT® BLUE VALUE VIP **LIST BILL:** YES, CO. NAME AND NO.

SOCIAL SECURITY NO. _____ LAST NAME (Print) _____ FIRST (Print) _____ MIDDLE (Print) _____ AC _____ PHONE NO. _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ DO YOU WANT COMBINED BILLING? YES NO

DATE OF BIRTH _____ MONTH _____ DAY _____ YEAR _____ MALE FEMALE MARITAL STATUS SINGLE MARRIED 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	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.				
		MO DAY YR	<input type="checkbox"/> HUSBAND	<input type="checkbox"/> WIFE	FULL-TIME STUDENT	DEPENDS UPON YOU FOR SUPPORT?	DATE DEPENDENCY BEGAN
*			<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> DAUGHTER	<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"/> DAUGHTER	<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"/> DAUGHTER	<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"/> DAUGHTER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	

*For dependents over age 20 who are full-time students and who would like to be covered under this Contract, please complete a Blue Cross and Blue Shield Dependent Certification form (24XX0205.1) available from your agent or by calling (800) 599-2583.

Does proposed insured/dependent live outside the above household? Yes No
If yes, please indicate dependent name and city and state of residence. _____

Do you or your dependents have, or had within 63 days, other health insurance including Medicare? Yes No If yes, please complete form 23XX1938.
Have you /dependent ever had Blue Cross and Blue Shield coverage? Yes No If yes, please provide: _____ Policy Number _____ Policyholder's Name _____

COVERAGE SELECTED – choose one APPLICANT ONLY APPLICANT AND SPOUSE APPLICANT AND ELIGIBLE CHILDREN APPLICANT AND SPOUSE AND ELIGIBLE CHILDREN (FAMILY)

<p><input type="checkbox"/> Blue Max Plan Deductibles: <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1000 (\$250 Pharm. Ded.) <input type="checkbox"/> \$2500 (\$500 Pharm. Ded.) <input type="checkbox"/> \$5000 (\$1000 Pharm Ded.) <input type="checkbox"/> Maternity Coverage (must select \$500 deductible or higher)</p>	<p><input type="checkbox"/> Blue Select Plan Deductibles: <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1000 <input type="checkbox"/> Blue Value Plan <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000 <input type="checkbox"/> Outpatient Rehabilitative Care Option (Blue Value option)</p>
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RISK LEVEL: PREFERRED STANDARD 1 STANDARD 2 STANDARD 3
VIP Plan: Preferred \$ _____ per day Budget \$ _____ per day Seniors (65-80) \$100 per day

Have you used tobacco in any form in the past 12 months? Yes No Has your spouse used tobacco in any form in the past 12 months? Yes No

<p>METHOD OF PAYMENT: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual <input type="checkbox"/> Bank Draft (Monthly)</p>	<p>Rate Calculation: Applicant \$ _____ Spouse \$ _____ Child(ren) \$ _____ App Fee \$ 25.00 (N/A for VIP) Total: \$ _____</p>	<p>Submitted with: <input type="checkbox"/> Check \$ _____ <input type="checkbox"/> Money Order \$ _____ <input type="checkbox"/> Other, please explain _____</p>
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1. I, the undersigned, do hereby apply for membership in Louisiana Health Service & Indemnity Company ("LHSIC"), 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 LHSIC constitute my contract with LHSIC. 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. If applying for Variable Income Plan Coverage, I have read the "Variable Income Plan Disclosure Notice."

3. I understand this document certifies that on Blue Value, I was offered the Rehabilitative Care Option and have made the election noted above.

4. PROXY-I hereby constitute and appoint the directors 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.**

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.

IMPORTANT! VIP applicants only answer questions marked with the *. For all Blue Max, Blue Select® and Blue Value applicants, 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 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

NAME	Date of Birth	Dependent Relationship to Subscriber (son, daughter, step-son, etc)	Coverage For: H-Health D- Dental	Coverage Effective Date M/D/Y	Coverage Termination Date M/D/Y	<i>If Group Policy.</i> Date waiting period/affiliation period began M/D/Y (if any) or N/A	<i>If Individual Policy,</i> Date a Substantially Complete Application Submitted M/D/Y or N/A
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							
DEPENDENT							

SECTION 3: AUTHORIZATION & CERTIFICATION BY SUBSCRIBER

I authorize Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. to verify all information provided with my prior carriers or employers. 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 or HMO Louisiana, Inc. as a result of misrepresented information on this form.

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 application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Subscriber Signature _____ Date _____

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



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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: _____



AUTHORIZATION TO DRA C E C S ON M A C C O U N T

As a convenience to me, I authorize Blue Cross and Blue Shield of Louisiana to start an automatic monthly charge to my account at the Bank (or other financial institution) I have named. I also authorize the Bank to debit the amount of those charges to my account.

I understand and agree that:

1. The Bank's rights with respect to each charge will be the same as if personally executed by me.
2. This authorization will remain in effect until I provide written notification to Blue Cross and Blue Shield of Louisiana that I wish to revoke it. I will allow Blue Cross and Blue Shield of Louisiana thirty (30) days to act on this notice.
3. Blue Cross and Blue Shield of Louisiana and my bank may discontinue this service.
4. I understand that if any such check be dishonored by my Bank and any monthly amount due Blue Cross and Blue Shield of Louisiana is not paid within the time stipulated in the policy, said policy shall become null and void except as otherwise provided therein.

23XX1346 R10/01

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

Name(s):

(Please Print)

(Signature)

(Date)

(Application Number - If Applicable)

(Name of Bank or Financial Institution)

(City)

(Checking Account Number)

(Blue Cross and Blue Shield of Louisiana Contract Number)

A B C M V