BlueCross BlueShield Enrollment / Change / Cancellation Form

Please check off choice of plan: ☐ **Standard** ☐ **Buy Up** ☐ **H.S.A.** ☐ **Decline Coverage***

Section A: Employee Information

***If declining coverage fill out first line of Section A and skip to Section D**

First Name:	Last Name:	MI:	Social Security Number:
Address: City: St: Zip:			Phone Number:
Date of Birth:	Sex: ☐Male ☐Female	Position: Location:	
Email Address:			
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed	Race - Check all that apply : ☐American Indian / Alaska Native ☐Asian ☐Black/African-American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other - Please Specify ______		

Section B: Family Information

List all family members that you wish to either Enroll or Cancel Coverage (Attach another sheet if necessary)

SPOUSE ☐**Cancel** ☐**Enroll** ☐ **VPSB Employee/Retiree**	First Name:	Last Name:	
	Social Security #:	Sex: ☐M ☐F	Date of Birth:
	Race - Check all that apply : ☐American Indian / Alaska Native ☐Asian ☐Black/African-American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other - Please Specify ______		
DEPENDENT ☐**Cancel** ☐**Enroll**	First Name:	Last Name:	
	Social Security #:	Sex: ☐M ☐F	Date of Birth:
	Race - Check all that apply : ☐American Indian / Alaska Native ☐Asian ☐Black/African-American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other - Please Specify ______		
DEPENDENT ☐**Cancel** ☐**Enroll**	First Name:	Last Name:	
	Social Security #:	Sex: ☐M ☐F	Date of Birth:
	Race - Check all that apply : ☐American Indian / Alaska Native ☐Asian ☐Black/African-American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other - Please Specify ______		
DEPENDENT ☐**Cancel** ☐**Enroll**	First Name:	Last Name:	
	Social Security #:	Sex: ☐M ☐F	Date of Birth:
	Race - Check all that apply : ☐American Indian / Alaska Native ☐Asian ☐Black/African-American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other - Please Specify ______		
DEPENDENT ☐**Cancel** ☐**Enroll**	First Name:	Last Name:	
	Social Security #:	Sex: ☐M ☐F	Date of Birth:
	Race - Check all that apply : ☐American Indian / Alaska Native ☐Asian ☐Black/African-American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other - Please Specify ______		

Please continue to Section C on back of page

Employer Section:

New Enrollment / Additions:	Cancellations:
Date of Hire ______ Date of Coverage ______	Effective Date of Cancellation: ______
☐New Hire ☐Birth ☐Marriage ☐Adoption	☐Cancel all Coverage ☐Cancel all listed in Section B
☐Court ordered dependent ☐Other ______	Reason:
☐Cobra Start Date ______ / End Date ______	☐Death ☐Divorce ☐Terminated
☐Annual Open Enrollment	☐Dependent reached max age
	☐Other ______

Date enterd NG

Date entered BCBS

Section C: Other Medical Coverage Information

On the day that this coverage begins will you, your spouse or any of your dependents be covered under any other medical health plan or policy including another BCBS plan or Medicare?

☐ Yes - please complete this section ☐ No - please skip to Section E.

Name of carrier: _____

Persons covered by other plan	Type B/S/F**	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

**B: Enter "B" if this dependent is covered under both you and yours spouse's insurance plan (married)
**S: Enter "S" if you are the parent awarded custody of the dependent and no other individual is required to pay for this dependent's medical expenses
**F: Enter "F" if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Section D: Waiver of Coverage

Declining coverage due to:	**I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form. I'm also aware of the VPSB Vesting policy and by waiving coverage future retire benefits may be reduced.**
☐Spouse's Employers's Plan ☐Individual Plan ☐Covered by Medicare ☐ Medicaid ☐COBRA from prior Employer ☐VA Eligible ☐Tri-Care ☐I (we) have no other coverage at this time ☐Other _____ ☐Covered with _____ who is a VPSB Employee/Retiree	
Date:	Signature:

Section E: Signature

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan. 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 crime and may be subject to fines and confinement in prison.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Coverage Conditions" statement which is included in this form.

Date:	Signature:

Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage(SBC), which summarizes important information about any health coverage option in standard format, to help you compare across options. The SBC is available on the web at: www.vpsb.net. A paper copy is also available by calling 337-898-5844.

COVERAGE CONDITIONS

1. I, the undersigned, do hereby enroll for coverage with Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana, Inc. (HMOLA) and/or Southern National Life Insurance Company, Inc. (SNLIC)for myself and any family members listed on this enrollment form. I understand that this enrollment/change form, together with the certificate of coverage, any riders and endorsements issued by Companies, constitute my only agreement with Companies. I understand that the contract as it pertains to me and my dependent(s) will be terminated within three years of the original effective date of coverage and all fees, less claims paid, will be refunded if I committed fraud or made an intentional misrepresentation of material fact in this enrollment/change form. I further understand that if enrolled for coverage with Blue Cross and Blue Shield of Louisiana, HMO Louisiana, Inc. or Southern National Life Insurance Company, Inc. that the contract issued by either company constitutes a contract solely between that company and the group/policy holder and that Blue Cross Blue Shield of Louisiana, HMO

2. I authorize any employer having information available as to employment, or other insurance coverage, regarding me or other family members proposed for coverage(s), to give the information to Companies or any agent acting on Companies' behalf. I understand this information will be used by the companies to determine eligibility or other related decisions deemed necessary for insurance coverage. I agree that a photographic copy of this authorization is as valid as the original. I hereby request the health coverage provided from time to time by my employer's group health plans, and I authorize deduction from my pay the amounts, if any, as may be

3. I understand that if I am declining enrollment for myself or my Dependents (including spouse), I may in the future be able to enroll myself or my Dependents in these plans, provided that I request enrollment within 30 days of the qualifying event. In addition, if I have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, I may be eligible to enroll myself or my dependents provided that I request enrollment

4. I acknowledge if I am eligible for Medicare, by reason of age, I have received a copy of "The Guide to Health Insurance For People With Medicare."

5. IT IS A DEPENDENT'S RESPONSIBILITY TO APPLY FOR CONTINUOUS COVERAGE ON A SEPARATE CONTRACT/CERTIFICATE WHEN ELIGIBILITY CEASES.

6. **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.

7. All of the questions in this application and in the health history section have been read by or to me and the answers provided by the enrollee and/or Dependent(s) if any, are true and correct to the best of my knowledge