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.

SOUTHERN NATIONAL LIFE INSURANCE COMPANY, INC.

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

GROUP MEMBER ENROLLMENT GUIDE

GroupCare

BlueSaver

PremierBlue

true BLUE

01MK2822 R06/10 Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company

Important Information

Customer Service:	1-800-599-2583
Authorizations:	1-800-523-6435
Corporate Headquarters:	225-295-3307

Corporate Headquarters physical address:

5525 Reitz Avenue

Baton Rouge, LA 70809

Corporate Headquarters Mailing Address:

P.O. Box 98029

Baton Rouge, LA 70898-9029

Website: www.bcbsla.com

Hours of Operation:

Corporate Headquarters: 8:00 a.m. – 4:30 p.m., Monday - Friday

Customer Service: 8:00 a.m. – 5:30 p.m., Monday - Friday

Dear New Member:

Thank you for choosing Blue Cross and Blue Shield of Louisiana and/or our subsidiaries for your insurance needs. This Member Enrollment Guide is designed to handle all details necessary for you to become our newest member. Included is an instruction page, your enrollment form and important notices.

Your decision to enroll puts you in good company. Founded in 1934, Blue Cross and Blue Shield of Louisiana is the oldest domestic health insurer in Louisiana. We're a Louisiana-owned and -operated company, employing more than 1,400 residents and serving more than one million Louisianians.

Because of our longstanding relationship with hospitals, physicians and other health care providers in the state, we are able to offer special features and pass on the cost savings to our members. All of our participating providers agree to accept our negotiated payment amount and not bill members for charges in excess of the negotiated price, and they agree to file claims on behalf of our members. You can find a list of network providers at www.bcbsla.com.

After you complete the member enrollment process, you will receive your ID card and your certificate of coverage. Your ID card includes your member number, some benefit information and helpful phone numbers. Carry your ID card with you at all times for instant recognition from providers. Your certificate of health coverage gives a full explanation of your benefits.

As a member, your ID card is honored throughout Louisiana. You can travel with confidence knowing that if you need care, the Cross and Shield is recognized by health care providers throughout the United States and in more than 200 countries throughout the world.

We appreciate your business and look forward to providing you with prompt claims payment and exceptional customer service. Thank you for your confidence in our company, and thank you for **Choosing Blue**. All of us at Blue Cross and Blue Shield of Louisiana look forward to serving you today and for many years to come.

01MK1720 R02/07

Instructions for Enrollee/Change Form

Please read thoroughly before completing the enrollment application/change form. Be sure to complete the enrollee information on the top of each page. Any incomplete forms will be returned for completion.

Check either "Employee Enrollment" or "Employee Change Form."

	Employers *For all employees, including new hires, the top of pages 2 thru 4 must be completed in full.* *Enrollment and New Hires: Enrollee's ID Number with their social security number and Group Number/Subgroup must be identified* *Changes: Enrollee's ID Number with their employee's member number and Group Number/Subgroup must be identified*
Section A Coverage Selections	• **Select** medical, dental and life coverage options offered by your employer. • **For medical coverage**, indicate your deductible/coinsurance amounts or the medical plan number, where applicable. • Be sure to check "Yes" if your group is a **Louisiana Association of Business and Industry** (LABI) group. If you're not sure, check with your group leader.
Section B Enrollee Information	• **If you are a new subscriber, complete the entire section**. • If you are an **established subscriber making changes or adding a dependent**, you only need to fill in your first and last name. • **Hire date:** if you are a rehire, note the date of your rehire in this section, not your original hire date. • **Marital status**: Other: Select this box if you are divorced or widowed.
Section C Enrollment Events	• **Select** "New" **if this is your group's initial enrollment with Blue Cross and/or HMO Louisiana or if you are a new hire serving eligibility.** • Select **"Late"** if you are enrolling during open enrollment or if you are changing products. • Select **"Rehire"** if you are a rehire and be sure to indicate your new hire date in Section B. • Select **"Special Enrollee**" if you have experienced a qualifying event and indicate the event at the bottom of Section C. ◦ If you are unsure what your class is, check with your group leader. ◦ For health, dental and life, check the appropriate box for the **product and coverage type** in which you are enrolling. ◦ Select **"I decline"** for the product(s) in which you are not enrolling. ◦ Complete the **"Waiver of Coverage"** box if you are waiving coverage. ◦ For a change of status, mark the appropriate box under "Change" of Section C. Indicate your qualifying event, if applicable, and be sure to give the day, month and year of the event.

Section D Employer Information	***To Be Completed By Employer*** • Group Leaders must complete this section if an employee is **MAKING A CHANGE** or if the **EMPLOYEE** is **CANCELING** coverage. • The group leader's signature is required for any changes indicated in this section. • **Product Selection Change:** If your group offers more than one medical plan and an employee is changing plans during open enrollment. You may need to also change the class of the employee. • **Subgroup Change:** If your group has billing set up for multiple locations or divisions and an employee is changing locations, the employee will be changing subgroups. Based on your billing subgroup number, indicate the subgroup they are moving from and the subgroup they are moving to. You may need to also change the class of the employee. • **Cancellation of Coverage**: Provide the reason the employee is canceling coverage and the last date of employment. • **Class Change**: Changes may result in a change to the employee's classification. Indicate the new class. A terminating employee will need COBRA or State Continuation class change indicated.
Section E Family Members	• In the first column, indicate the family members who are **enrolling (E), changing (C)** or **deleting (D).** • Complete each applicable section in full. • An **out-of-area dependent** is a dependent who lives out-of-state.
Section F Life Insurance Information	• If you are **splitting your life insurance** among beneficiaries, you must indicate the percentage that should go to each beneficiary. • If you do not indicate a beneficiary, the beneficiary will automatically be designated as the "**estate of."**
Section G Other Coverage Information	**Complete this section only if you or your dependents have other coverage.** • Please give the complete names of your dependents. We cannot accept "mother," "daughter," etc. • Type of Coverage: **Comprehensive** coverage includes a full-coverage employer sponsored or individually owned health insurance plan. **Limited Benefit** coverage includes an employer sponsored or individually owned policy which is specific in the type of coverage provided. For example dental, vision, cancer, specific disease, hospital indemnity or a limited coverage group medical policy.
Section H Medical History	• Complete this section if required by your group. • Provide an explanation of medical conditions you checked using the Medical Questionnaire Guide. If the guide is not available, provide details in the second table listed.
Section I Coverage Conditions	• Please carefully read this section and sign and date.

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❑ EMPLOYEE ENROLLMENT ❑ EMPLOYEE CHANGE FORM

PLEASE PRINT AND COMPLETE IN BLACK INK ONLY

SECTION A - COVERAGE SELECTIONS

Blue Cross and Blue Shield of Louisiana
- ❑ PPO (Ded/Coins.) _____
- ❑ TrueBlue (Ded/Coins.) _____
- ❑ Blue*Saver* (Ded/Coins.) _____
- ❑ Premier Blue (Plan #) _____
- ❑ Dental

HMO Louisiana, Inc.
- ❑ HMO (Plan #) _____
- ❑ POS (Plan #) _____

LABI
- ❑ Yes
- ❑ No

Southern National Life Insurance Company, Inc.
- ❑ Life/AD&D
- ❑ Dependent Life
- ❑ Short Term Disability

SECTION B - EMPLOYEE INFORMATION

ENROLLEE'S LAST NAME	FIRST	MI	SEX (M/F)	BIRTHDATE (MM/DD/YYYY)	HIRE DATE	OCCUPATION	SOCIAL SECURITY NUMBER

MAILING ADDRESS	CITY	STATE	ZIP	E-MAIL ADDRESS	HOME PHONE	WORK PHONE

MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ OTHER (explain below)	RETIRED ❑ YES ❑ NO	DATE RETIRED	EMPLOYER NAME

SECTION C - ENROLLMENT EVENTS

ENROLLMENT **Requested Effective Date** ____/____/____

❑ New ❑ Late ❑ Rehire ❑ Special Enrollee (Go to Qualifying Event Section Below.)

Class (Select One): ❑ Active ❑ Management ❑ Non-Management ❑ Retiree ❑ COBRA/State Continuation* ❑ Other

*Please complete form 23XX0500 for BCBSLA products and form 03100 00081 for HMO products.

I am enrolling for:

❑ **Health**: ❑ Employee Only ❑ Employee & Spouse ❑ Employee & Dependent Child(ren) ❑ Employee and Family ❑ I Decline

❑ **Dental**: ❑ Employee Only ❑ Employee & Spouse ❑ Employee & Dependent Child(ren) ❑ Employee and Family ❑ I Decline

❑ **Life**: ❑ Employee Only ❑ Employee & Spouse ❑ Employee & Dependent Child(ren) ❑ Employee and Family ❑ I Decline

WAIVER OF COVERAGE

I decline to enroll for this coverage due to:

❑ Spouse's Employer Plan

❑ Individual Plan ❑ Medicare

❑ COBRA from Prior Employer

❑ VA Eligibility ❑ Medicaid ❑ Tri-Care

❑ Other _____

If waiving all coverages, please go to Section I, read and sign.

CHANGE (Please complete Section E) **Requested Effective Date** ____/____/____

Type of Change: ❑ Name ❑ Address ❑ Add Dependent ❑ Delete Dependent ❑ Subgroup ❑ Class ❑ Cancellation ❑ Qualifying Event (Complete next section)

QUALIFYING EVENT ❑ Marriage ❑ Birth ❑ Adoption ❑ Placement for Adoption **Date of Qualifying Event Date** ____/____/____

If you lost other coverage, was it due to: ❑ Divorce ❑ Death ❑ Termination or reduction in work hours ❑ Employer contributions for coverage ended ❑ Other _____ ❑ COBRA coverage exhausted (Refer to instruction page)

SECTION D - EMPLOYER INFORMATION (TO BE COMPLETED BY THE EMPLOYER)

The information below must be completed by the Employer if an employee is making a change, or if the employee is canceling coverage.

Employer Name _____ Employer Signature _____ Date ____/____/____ Group/Subgroup Number _____/_____

Product Selection Change (please refer to instruction page) _____ Subgroup Change: Move From _____ Move To _____

Cancellation of Coverage: ❑ Cancel Coverage (reason) _____ Last Date of Employment ____/____/____

Class Change To: ❑ Active ❑ Management ❑ Non-Management ❑ COBRA/State Continuation* ❑ Retiree ❑ Other (Explain) _____

*Note: If choosing COBRA or Louisiana State Continuation, please complete form 23XX0500 for BCBSLA products or 03100 00081 for HMOLA products.

NOTICE FOR ENROLLEES ON HMO PLANS THAT DO NOT CONTAIN A POINT-OF-SERVICE BENEFIT: 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 THOSE HEALTH CARE SERVICES AND DRUGS REQUIRE AN AUTHORIZATION BY THE PLAN

Enrollee's Last Name ______ Enrollee's First Name ______ Enrollee's ID Number ______ Group Number/Subgroup ____ / ____

SECTION E - FAMILY MEMBERS TO BE ENROLLED, CHANGED OR DELETED

ENROLL, CHANGE OR DELETE (Please circle the appropriate answer)	DEPENDENT'S FULL NAME (LAST, FIRST, MI)	RELATIONSHIP (If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered attach a copy of the order.)	BIRTHDATE	SOCIAL SECURITY NUMBER	LIVES WITH YOU IF "NO" GIVE ADDRESS/ LOCATION**	MENTALLY OR PHYSICALLY INCAPACITATED***	OUT OF AREA DEPENDENT/ STUDENT
E C D	SPOUSE	❑ HUSBAND ❑ WIFE			N/A	N/A	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ____			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ____			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ____			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ____			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
E C D		❑ SON ❑ STEPSON ❑ DAUGHTER ❑ STEPDAUGHTER ❑ OTHER ____			❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO

**Address/Location ______

***If your dependent is mentally or physically incapacitated, please provide the following medical documentation from your doctor:
- Diagnosis of condition(s) causing incapacitation
- Date patient/dependent first became incapacitated
- Anticipated length of incapacitation
- Additional information needed

SECTION F - LIFE INSURANCE INFORMATION

Job Title: ______ Salary: ______ ❑ Monthly ❑ Annually

PRIMARY LIFE BENEFICIARIES

LAST NAME ______ FIRST NAME ______ MI ____ DATE OF BIRTH ___/___/___ RELATIONSHIP TO YOU ______ Percent ____ %

LAST NAME ______ FIRST NAME ______ MI ____ DATE OF BIRTH ___/___/___ RELATIONSHIP TO YOU ______ Percent ____ %

SECONDARY LIFE BENEFICIARIES: Contingent on the above-named beneficiaries' death, please designate the following as my Life Beneficiary:

LAST NAME ______ FIRST NAME ______ MI ____ DATE OF BIRTH ___/___/___ RELATIONSHIP TO YOU ______ Percent ____ %

LAST NAME ______ FIRST NAME ______ MI ____ DATE OF BIRTH ___/___/___ RELATIONSHIP TO YOU ______ Percent ____ %

SECTION G - OTHER COVERAGE INFORMATION

Do you or any dependents have other health insurance? ❑ Yes ❑ No
Blue Cross and Blue Shield? ❑ Yes ❑ No

Other Group? ❑ Yes ❑ No

If yes to either give: Policyholder ______ Insurance Company ______

COMPLETE FOR EACH PERSON AGE 19 AND OLDER	List Members Covered	Coverage Start Date	Coverage End Date	Prior Insurance Carrier and Policy Number	Type of Coverage (Refer to Instruction Page)
Has anyone on this application been covered with health benefits, including coverage with Blue Cross and Blue Shield of Louisiana, within the past 63 days? ❑ Yes ❑ No					❑ Comprehensive ❑ Limited Benefit
If yes, complete the information on the right.					❑ Comprehensive ❑ Limited Benefit
					❑ Comprehensive ❑ Limited Benefit
If more than one prior carrier, please provide a certificate of coverage from other carrier(s).					❑ Comprehensive ❑ Limited Benefit
					❑ Comprehensive ❑ Limited Benefit

Are you or any of your dependents covered by Medicare? ❑ Yes ❑ No If yes, complete the information on the right.	Name	Reason	Covered by:	Dates Medicare became effective	Medicare Numbers
		❑ Over 65 ❑ Disabled ❑ End Stage Renal Disease	❑ Part A ❑ Part B ❑ Medicare Advantage ❑ Part D	A. ___/___/___ B. ___/___/___ C. ___/___/___ D. ___/___/___	A. ____ B. ____ C. ____ D. ____
		❑ Over 65 ❑ Disabled ❑ End Stage Renal Disease	❑ Part A ❑ Part B ❑ Medicare Advantage ❑ Part D	A. ___/___/___ B. ___/___/___ C. ___/___/___ D. ___/___/___	A. ____ B. ____ C. ____ D. ____

Enrollee's Last Name	Enrollee's First Name	Enrollee's ID Number	Group Number/Subgroup
			/

Are you or any of your dependents currently receiving disability/Workers' Comp Benefits? ❑ Yes ❑ No If yes, complete the information on the right.	Name	Date Coverage Began	Name	Date Coverage Began
		/ /		/ /
		/ /		/ /
		/ /		/ /

SECTION H - MEDICAL HISTORY

Any personal health information (PHI) obtained by Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana Inc. (HMOLA), and/or Southern National Life Insurance Company, Inc. (SNL) in connection with the enrollment form may be retained by BCBSLA, HMOLA and/or SNL and used or disclosed in connection with future underwriting/renewal efforts.

IMPORTANT! PLEASE ANSWER ALL QUESTIONS BELOW FOR ALL ENROLLEES. FOR EACH "YES" RESPONSE, PROVIDE DETAILS ON PAGE 4

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	8. Abnormal blood pressure?	❑ Yes	❑ No
2. Any type of cancer?	❑ Yes	❑ No	9. Heart trouble?	❑ Yes	❑ No
3. Any blood disorder?	❑ Yes	❑ No	10. Tuberculosis?	❑ Yes	❑ No
4. A stroke (CVA)?	❑ Yes	❑ No	11. Other lung problems?	❑ Yes	❑ No
5. Circulatory problems?	❑ Yes	❑ No	12. HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC?	❑ Yes	❑ No
6. Epilepsy?	❑ Yes	❑ No			
7. Rheumatic fever?	❑ Yes	❑ No	13. Hepatitis or a liver disorder?	❑ Yes	❑ No

IN THE LAST 5 YEARS HAS ANYONE APPLYING FOR COVERAGE HAD OR BEEN DIAGNOSED WITH:

14. Asthma, bronchitis or chronic sinus trouble?	❑ Yes	❑ No	28. Female reproductive problems?	❑ Yes	❑ No
15. Allergies?	❑ Yes	❑ No	29. Pelvic pain?	❑ Yes	❑ No
16. Arthritis?	❑ Yes	❑ No	30. Gall stones or gall bladder disorder?	❑ Yes	❑ No
17. Rheumatism/Bursitis or Sciatica?	❑ Yes	❑ No	31. Abdominal pain?	❑ Yes	❑ No
18. Had any bodily deformities?	❑ Yes	❑ No	32. Ulcers, stomach, colon or other intestinal disorders, adhesions?	❑ Yes	❑ No
19. Any back/orthopedic condition or muscular diseases?	❑ Yes	❑ No	33. Any eye conditions (excluding corrective lenses)?	❑ Yes	❑ No
20. Tumors or cysts?	❑ Yes	❑ No	34. Any ear condition or impairment?	❑ Yes	❑ No
21. Kidney stones or urinary system disorders, diabetes insipidus or prostate disorders?	❑ Yes	❑ No	35. A mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation?	❑ Yes	❑ No
22. Endocrine disorder thyroid problem or goiter?	❑ Yes	❑ No	36. Candidiasis (yeast infection), herpes, syphilis, gonorrhea, condylomata acuminata (genital warts), or other sexually transmitted diseases?	❑ Yes	❑ No
23. Hemorrhoids/rectal ailments or varicose veins?	❑ Yes	❑ No			
24. A hernia?	❑ Yes	❑ No			
25. Seizures, Fainting Spells?	❑ Yes	❑ No	37. Alcohol or substance abuse, detoxification?	❑ Yes	❑ No
26. Headaches?	❑ Yes	❑ No	38. Any condition (including developmental defects or deformities) of oral cavity, jaw, facial or cranial bones, teeth and surrounding structures?	❑ Yes	❑ No
27. Irregular/excessive menstrual bleeding?	❑ Yes	❑ No			

MISCELLANEOUS:

39. Are you expecting a biological child within the next 9 months (male or female applicant)?	❑ Yes	❑ No	43. Have you, or anyone on this application, ever had any health insurance postponed, rated, ridered, declined, cancelled, or had reinstatement refused?	❑ 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?	❑ Yes	❑ No	44. Have you, or anyone on this application, ever had any departure from good health or any medical or surgical advice or treatment from any medical practitioner (medical doctor/surgeon, podiatrist, chiropractor, dentists/oral surgeons, etc.) in the last 5 years?	❑ Yes	❑ No
42. Are you, or anyone on this application, engaged in private flying, parachuting, hang gliding, racing, underwater diving, handling of explosive materials or hazardous wastes or materials?	❑ Yes	❑ No			

Enrollee's Last Name _____ Enrollee's First Name _____ Enrollee's Number _____ Group Number/Subgroup _____ / _____

PROVIDE DETAILS ACCORDING TO THE MEDICAL QUESTIONNAIRE GUIDE - ATTACH ADDITIONAL PAGES IF NECESSARY

Question #	Person	Condition/Diagnosis	A	B	C	D	E	F	G

IF MEDICAL QUESTIONNAIRE IS UNAVAILABLE, PROVIDE DETAILS FOR EACH "YES" RESPONSE IN THE FORMAT BELOW. ATTACH ADDITIONAL PAGES IF NECESSARY

Question #	Person	Condition/Diagnosis	Treatment/Complications	Physician's Name	Dates Treated	Medications, Frequency, Dosage

SECTION I - 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. (SNL) 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 and intentional misrepresentation of material fact in this enrollment/change form.
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 necessary. The information given on this application is true and correct to the best of my knowledge and belief.
3. I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after coverage ends. 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 within 30 days after the marriage, birth, adoption or placement for adoption.
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 and belief.

X _____ Date _____

Enrollee's Signature **Enrollee's Signature Date**

OFFICE USE ONLY

01 _____ 02 _____ 03 _____ 04 _____

SUBSCRIBER ID NUMBER	GROUP NO.	SUBGROUP	CL	PRODUCT ID	HEALTH OED	WC	UW INT. HLTH. DT.	DENT. TY/CL	DENT. WC	LIFE OED	LIFE CL

LIFE COV.	BASIC	SUPP	**MEDICALLY UNDERWRITE:**	❑ BASIC LIFE	❑ SUPP. LIFE	❑ HEALTH	LIFE CODE	OUT OF ELIG.? ❑YES ❑NO	BASIC ELIG AMT.	BASIC GI AMT.	SUPP. ELIG. AMT.	SUPP. GI. AMT.

Attach additional pages if necessary