Louisiana HMO Louisiana SOUTHERN NATIONAL LIFE INSURANCE COMPANY, INC.

APPLICATION FOR GROUP COVERAGE

❑ NEW GROUP ❑ NEW SUB-GROUP ❑ DUAL CHOICE

SECTION A - COVERAGE SELECTION

Blue Cross and Blue Shield of Louisiana

❑ GroupCare PPO (Plan) ______

❑ BlueSaver (Plan) ______

❑ Premier Blue (Plan) ______

❑ Other (Plan) ______

HMO Louisiana, Inc.

❑ HMO (Plan) ______

❑ Blue POS (Plan) ______

❑ Community Blue POS (Plan) ______

❑ BlueConnect POS ______

❑ BlueConnect Acadiana ______

NOTICE - YOUR EMPLOYEES MUST PERSONALLY BEAR ALL COSTS IF THEY UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

Southern National Life Insurance Company, Inc.

❑ Group Term Life
- ❑ AD&D*
- ❑ Dependent Life*

❑ Short Term Disability

❑ Long Term Disability

❑ Voluntary Life
- ❑ AD&D - Voluntary**
- ❑ Spouse** ❑ Child**

❑ Voluntary High-Limit AD&D

❑ Voluntary Short Term Disability

❑ Voluntary Long Term Disability

*Only available with Life coverage

**Only available with Voluntary Life coverage

Blue Dental for Small Group Certified: ❑ Preferred Plus ❑ Preferred ❑ Essential

Traditional Blue Dental: ❑ Group ❑ Voluntary

Plan name: ______ or Other ______ (Indicate dual option if applicable)

Vision

❑ Group ❑ Voluntary

❑ Plan 1 ❑ Plan 2 ❑ Plan 3

Association ❑ Yes ❑ No If yes: ❑ LABI ❑ LADA ❑ LFA

SECTION B - GROUP INFORMATION

Legal Name of Policyholder/Group			Requested Effective Date
Contact Name and Title		Group Number	Sub-Group
Physical Address	City	State Zip Code	Telephone Number
Mailing Address	City	State Zip Code	Fax Number
Federal Tax ID Number	Contact Name's E-mail Address	Type of Business ❑ Proprietorship ❑ Partnership ❑ Corporation ❑ LLC ❑ Other ______	SIC

Church plan? ❑ Yes ❑ No Government plan? ❑ Yes ❑ No Collectively bargained plan? ❑ Yes ❑ No School board or charter school? ❑ Yes ❑ No

SECTION C - SUBGROUP/LOCATIONS ❑ None ❑ Yes - List names and plan addresses below

Name	Address	Sub-Group ID

Will you be submitting one (1) payment? ❑ Yes ❑ No Will each location submit a separate payment? ❑ Yes ❑ No

Do you want to receive separate invoices for each location listed above? ❑ Yes ❑ No

SECTION D - PRODUCT INFORMATION/EMPLOYER CONTRIBUTION/PARTICIPATION

Name of previous carrier Medical ______ Dental ______ Vision ______

Were you covered with Blue Cross and Blue Shield of Louisiana within the last three years? ❑ No ❑ Yes – Group Number ______

Financial Arrangement: ❑ Fully-Insured ❑ Self Funded - SBFS ❑ Self Funded - Traditional ❑ Other ______

Group Subject to: ❑ COBRA ❑ State Continuation ❑ Other

ATTACH SIGNED MEDICAL, DENTAL, VISION, LIFE AND DISABILITY PROPOSALS FOR COVERAGES SELECTED

ADMINISTRATIVE SERVICES ONLY (ASO) AND NON-STANDARD FULLY-INSURED GROUPS: YOUR GROUP MEDICAL BENEFITS CHECKLIST MUST BE ATTACHED

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company.
HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc. are subsidiaries of Blue Cross and Blue Shield of Louisiana.
All three companies are independent licensees of the Blue Cross and Blue Shield Association.

Medical Loss Ratio (MLR)

The Patient Protection and Affordable Care Act (Affordable Care Act) includes a requirement that insurance companies report their medical loss ratio (MLR) to state and federal agencies, and pay rebates if certain MLR targets are not met. The calculation of the MLR is based, in part, on the size of the insurance companies' employer groups. Based on the information you provide, your group will be categorized as "small" or "large" for the purposed of applying the MLR requirements. This categorization will be used to determine whether your group will be eligible for rebates, if any.

Providing this information does not impact eligibility or participation requirements. Information needed to verify eligibility or participation will be requested separately.

What was the average number of employees employed by your company in the previous calendar year including owners? ________________

*In the case of an employer which was not in existence in the previous year, response should be based on the average number of employees that is reasonably expected to be employed on business day in current year.

Please note: average must include all individuals owning or employed by the company and any affiliated company in the preceding calendar year, whether an employee was full-time, part-time and/or seasonal. Practically speaking, employees include all those issued a W-2, regardless of hours worked or enrollment in the health plan.

Employer Contribution	Employee %	Dependent %	Employee $	Dependent $
Medical				
Dental				
Vision				

Participation

	Total Eligible	No. Total Ineligible	No. Serving Eligibility	No. COBRA/LA Continuation	No. Retirees Covered	No. Elsewhere Credits	No. Waivers	Total No. Enrolled
Medical								
Dental								
Vision								

Medicare Secondary Payer (MSP)

1. Did your company employ 100 or more full-time, part-time, intermittent, leased and/or seasonal employees on 50 percent or more of its regular business days during the previous calendar year, whether or not the employee is enrolled in Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. health coverage?

   Yes ❑ No ❑

   If yes, please provide the date that this threshold was reached ______/______/______

2. Did your company employ 20 or more full-time, part-time, intermittent, leased and/or seasonal employees for each working day in 20 or more calendar weeks in the previous or current calendar year, whether or not the employee is enrolled in Blue Cross or HMO Louisiana health coverage?

   Yes ❑ No ❑

   If yes, please provide the date that this threshold was reached ______/______/______

   If no, and at any point if your company employs "20 or more employees," as defined above and explained in the frequently asked questions, you must promptly notify us of this development. To download the form, go to www.bcbsla.com, log in to AccessBlue, select "Forms for Employers," then choose the Federal Tax ID Group Size Information Sheet, or call Customer Service at 1-800-711-5520 to request the form.

3. If your company participates in a multiple-employer plan (such as an association) or a multi-employer plan (such as a collectively bargained health and welfare fund), and the Centers for Medicare & Medicaid Services (CMS) has granted a Small Employer Exception request for any of your employees who are enrolled in Blue Cross or HMO Louisiana health coverage, please provide a copy of any relevant Small Employer Exception approval letters.

   Note, if you answer Yes to both question #1 and question #2, we will report your answer to #1 in our mandatory report to CMS.

SECTION E - ELIGIBILITY/WAITING PERIOD

Are retirees eligible for coverage? ❑ Yes ❑ No Are owners eligible for coverage? ❑ Yes ❑ No Are elected officials eligible for coverage? ❑ Yes ❑ No

1. On groups excluding classes of employees from coverage, please attach the most current SUTA (Quarterly Wage & Tax Report) indicating all employees by corresponding job titles.
2. School Boards will receive OGB eligibility rules as required by Louisiana law.
3. Please complete the following.

Applies to Product(s) below:		
❑ Medical ❑ Dental ❑ Vision ❑ Life ❑ Short Term Disability ❑ Long Term Disability ❑ Voluntary ______________________	❑ Medical ❑ Dental ❑ Vision ❑ Life ❑ Short Term Disability ❑ Long Term Disability ❑ Voluntary ______________________	❑ Medical ❑ Dental ❑ Vision ❑ Life ❑ Short Term Disability ❑ Long Term Disability ❑ Voluntary ______________________
Eligibility	**Eligibility**	**Eligibility**
❑ Date of Hire ❑ First billing date on or after date of hire ❑ First billing date on or after 30 days from the date of hire ❑ First billing date on or after 60 days from the date of hire; not to exceed 90 days	❑ Date of Hire ❑ First billing date on or after date of hire ❑ First billing date on or after 30 days from the date of hire ❑ First billing date on or after 60 days from the date of hire; not to exceed 90 days	❑ Date of Hire ❑ First billing date on or after date of hire ❑ First billing date on or after 30 days from the date of hire ❑ First billing date on or after 60 days from the date of hire; not to exceed 90 days
Eligibility Class Description(s): Insert specific eligible job titles under Eligibility Class Description		
❑ All Active Eligible ❑ Management* ❑ Non-management* ❑ Other* *Note all eligible job titles below	❑ All Active Eligible ❑ Management* ❑ Non-management* ❑ Other* *Note all eligible job titles below	❑ All Active Eligible ❑ Management* ❑ Non-management* ❑ Other* *Note all eligible job titles below

Disclaimer: On groups excluding classes of employees from coverage, job titles not listed above are considered **ineligible**. Applications received with ineligible job titles will not be processed and will be returned to the Group Leader.

Prior Carrier Eligibility for Medical	Prior Carrier Eligibility for Dental

SPECIAL INFORMATION FOR NON-GRANDFATHERED GROUPS THAT VIOLATE SALARY NONDISCRIMINATION RULES AND REGULATIONS (IRS enforcement of this law has been delayed until federal regulations are issued)

The Affordable Care Act requires insured groups to comply with Salary Nondiscrimination rules and regulations. Previously these rules applied only to self funded groups. Nondiscrimination testing applies to eligibility, benefits, utilization (actual participation), and controlled groups. Testing failure may mean that the group will have to pay very high excise tax penalties ($100 per day per impacted person).

Group understands that if it performs, or requests that carrier perform any of the following non-exclusive acts, it could implicate the need for Group to perform nondiscrimination testing under section 105(h) of the Internal Revenue Code. Group understands that carrier does not perform nondiscrimination testing and Group assumes all obligations of testing.

- Failure to offer coverage to all eligible employees
- Having too many highly compensated or key employees on the plan relative to rank and file employees
- Failure to provide the same waiting periods to all eligible employees
- Treating employees differently based on age, years of service, or compensation
- Contributing a different percentage of premium for different classes of employees
- Providing different benefits for different classes of employees
- Creating any differences in coverage or cost of coverage for any class of employee

Group understands that legal and tax implications of all requests it has made to Company, and understands that if it violates Salary Nondiscrimination rules and regulations they may have to pay excise taxes of up to $100 per day per impacted person, to be self reported to the Internal Revenue Service.

SECTION F - LIFE INSURANCE

If multiple benefit classes, attach copy of this page indicating class coverage per proposal	Group Term Life/AD&D	Voluntary Term Life/AD&D	Voluntary High Limit AD&D
	❑ All Active Eligible ❑ Management ❑ Non- Management ❑ Other class #__________ *(must coincide with class # in section E)*	❑ All Active Eligible ❑ Management ❑ Non- Management ❑ Other class #__________ *(must coincide with class # in section E)*	❑ All Active Eligible
Accidental Death & Dismemberment	❑ Include	❑ Include	
Coverage Amount **GI = Guarantee Issue** **Max = Maximum**	❑ _____Times Salary ❑ Flat Amount $__________________ GI $_____________ Max $___________	❑ Up to 5 times salary ❑ ____, ____, ____ time's salary (not to exceed 5 times salary) ❑ Flat $10,000 increments GI $____________ Max $________ (Populate based on group size & participation)	Coverage elected in $10,000 increments from $50,000 to $250,000 employee max
Reduction Schedule	Composite & age rated LABI (By 35% @ 65, by 50% at 70, term at retirement) Age-Rated (non-LABI) (By 35% @ 65, to $2,000 at 70, term at retirement) ❑ Other ______________________	By 35% at age 70 By 50% at age 75 By 70% at age 80 Terminates at retirement ❑ Other ___________________	By 35% at age 70 By 50% at age 75 By 70% at age 80 By 85% at age 85 Terminates at retirement
Portability	Standard: Not Included ❑ Other ______________________	Included - VGTL Only	Not Included
Dependent Life	**Spouse** / **14 Days - Age 26** ❑ $5,000 / $2,500 ❑ $10,000 / $5,000 **LABI Only** ❑ $5,000 / $5,000 ❑ $10,000 / $10,000	Spouse ❑ Include Child(ren) ❑ $10,000 (6 months old - age 26) ❑ Other _________________	

SECTION G - DISABILITY INSURANCE

If multiple benefit classes, attach copy of this page indicating class coverage per proposal	Group Short Term Disability	Voluntary Short Term Disability	Group Long Term Disability	Voluntary Long Term Disability
	❑ All Active Eligible ❑ Management ❑ Non- Management ❑ Other Class __________ ❑ Core ❑ Buy-Up Option# _____	❑ All Active Eligible ❑ Management ❑ Non- Management ❑ Other Class __________ ❑ Incremental Plan	❑ All Active Eligible ❑ Management ❑ Non- Management ❑ Other Class __________ ❑ Core ❑ Buy-Up Option# _____	❑ All Active Eligible ❑ Management ❑ Non- Management ❑ Other Class __________ ❑ Incremental Plan
Benefit Percentage	❑ 50% ❑ 60% ❑ 66 2/3% ❑ Other ____________	❑ 50% ❑ 60% ❑ 66 2/3% ❑ Other ____________	❑ 50% ❑ 60% ❑ 66 2/3% ❑ Other ____________	❑ 50% ❑ 60% ❑ 66 2/3% ❑ Other ____________
Guarantee Issue	Weekly: $______________	Weekly: $______________	Monthly: $______________	Monthly: $______________
Benefit Minimum	Weekly: ❑ $25 ❑ $50 ❑ $0	Weekly: ❑ $25 ❑ $50 ❑ $0	Monthly: ❑ $50 ❑ $100 ❑ Greater of 10% or $100	Monthly: ❑ $50 ❑ $100 ❑ Greater of 10% or $100
Benefit Maximum	Weekly: $______________	Weekly: $______________	Monthly: $______________	Monthly: $______________
First Day Hospital	❑ No ❑ Yes	❑ No ❑ Yes		
Benefits Commence (Days Accident/Days Illness)	❑ 1/8 ❑ 8/8 ❑ 15/15 ❑ 30/30 ❑ Other______	❑ 1/8 ❑ 8/8 ❑ 15/15 ❑ 30/30 ❑ Other______		
Continuity of Coverage	❑ Not Included ❑ No Loss/Gain	❑ Not Included ❑ No Loss/Gain	❑ Not Included ❑ No Loss/Gain	❑ Not Included ❑ No Loss/Gain
Elimination Period			❑ 90 Days ❑ 120 Days ❑ 150 Days ❑ 180 Days ❑ Other __________	❑ 90 Days ❑ 120 Days ❑ 150 Days ❑ 180 Days ❑ Other __________
Benefit Duration	❑ 9 weeks ❑ 11 Weeks ❑ 13 weeks ❑ 26 Weeks ❑ Other ______________	❑ 9 weeks ❑ 11 Weeks ❑ 13 weeks ❑ 26 Weeks ❑ Other ______________	❑ ADEA 1 w/SSNRA ❑ ADEA 2 ❑ ADEA 1 W/RBD ❑ ADEA 3 ❑ 2 year graded ❑ 5 year graded w/RBD ❑ Other __________________	❑ ADEA 1 w/SSNRA ❑ ADEA 2 ❑ ADEA 1 W/RBD ❑ ADEA 3 ❑ 2 year graded ❑ 5 year graded w/RBD ❑ Other __________________
Definition of Disability (*Own Occupation)			❑ *OO _____ months, any OCC ❑ Any OCC ❑ Other _______ ❑ *OO _____ months, alt any	❑ *OO _____ months, any OCC ❑ Any OCC ❑ Other _______ ❑ *OO _____ months, alt any
Pre-Existing Condition Limitation		❑ 3/6/12 ❑ _______	❑ 3/12 ❑ 12/24 ❑ 3/6/12 ❑ 12/12 ❑ 12/6/24 ❑ _____	❑ 3/12 ❑ 12/24 ❑ 3/6/12 ❑ 12/12 ❑ 12/6/24 ❑ _____
Social Security Offset			❑ Primary ❑ Family ❑ Other _______________	❑ Primary ❑ Family ❑ Other _______________
Cost of Living Adjustment (COLA)			❑ Included ❑ Not Included	
Activities of Daily Living			❑ Included ❑ Not Included	
Accidental Dismemberment Loss of Sight			❑ Included ❑ Not Included	
Mental & Substance Abuse			❑ 12 months ❑ 24 months ❑ 36 months	❑ 12 months ❑ 24 months ❑ 36 months
Survivor Benefit			❑ 3 months ❑ 6 months	❑ 3 months ❑ 6 months

SECTION H - SOUTHERN NATIONAL LIFE EMPLOYER CONTRIBUTION/WAITING PERIOD/PARTICIPATION

Required	Employer Contribution EE	Employer Contribution Dep	(A) Eligible Employees	Company Use Only (B) Enrolled Employees	Company Use Only (B/A) % Participation	Prior Carrier Name (Include copy of policy)	Prior Carrier Effective Date	Prior Carrier Term Date
Life/AD&D	%	N/A						
Dependent Life	N/A	%						
Long Term Disability	%	N/A						
LTD Buy-Up								
Short Term Disability	%	N/A						
STD Buy-Up								
Voluntary Life/AD&D	%	N/A						
Voluntary Spouse/Child Life	N/A	%						
Voluntary LTD	%	N/A						
Voluntary STD	%	N/A						
Voluntary High Limit AD&D	%	N/A						

SECTION I - GROUP AGREEMENT

BY ACCEPTING BENEFITS UNDER THESE BENEFIT PLANS, GROUP/POLICYHOLDER AGREES TO THE FOLLOWING:

Medical Products:

1. It is agreed that the Group will maintain standard participation percentages of medical enrollment as indicated on the signed proposal.
2. It is agreed that the new employees will enroll for coverage immediately, to be effective according to the eligibility requirements stated in the Benefit Plan, with the employer paying a minimum of 50% or __________of each employee's premium.
3. It is agreed that Blue Cross and Blue Shield of Louisiana and its subsidiaries will be the exclusively endorsed carriers for comprehensive medical coverage.
4. I recognize BCBSLA and HMOLA Producer # _________ as the producer of record for my Group's medical benefit plan(s) and acknowledge that the producer may receive commissions as indicated below:

   For Fully Insured

   ❑ 10% graded commission (2-99 Subscribers)

   ❑ 100+ Subscriber (Based on standardized commission schedule)

   Group Contact Initials

   I acknowledge that producer may receive additional compensation and/or incentives based on other factors such as growth, premium volume, and loss ratio or claims experience. The additional compensation may be from 0 to 4 percent, with an average of 2 percent.

   I also acknowledge that BCBSLA and HMOLA may pay a fee to certain entities. These fees are not directly related or attributable to the premiums paid by the group. Fees are for the purpose of administrative and consulting services.

   ❑ Agency Fee- available for Fully Insured groups with 100+ enrolling contracts ____________________________

   For Self Funded

   ❑ Per employee per month _____________________ ❑ Other ______________________

Dental Products:

5. It is agreed that the Group will maintain participation percentages of dental enrollment as indicated on the signed proposal.
6. It is agreed that the new employees will enroll for coverage immediately, to be effective according to the eligibility requirements stated in the Benefit Plan, with the employer paying a minimum of 0% or ________% of each employee's premium.
7. It is agreed that BCBSLA and its subsidiaries will be exclusively endorsed carriers for the stand-alone dental coverage.
8. I recognize BCBSLA Producer #________as the producer of record for my Group's dental benefit plan(s) and acknowledge that the producer may receive commissions as indicated below:

   ❑ Certified Blue Dental 10% level commission

   ❑ Traditional Blue Dental 10% level commission

   ❑ Traditional Other_______________________

   Group Contact Initials

   I acknowledge that producer may receive additional compensation and/or incentives based on other factors such as growth. The additional compensation may be from 0 to 4 percent, with an average of 2 percent.

Vision Products:

9. I recognize BCBSLA Producer #________________ as the producer of record for my Group's Vision benefit plan(s) and acknowledge that the producer may receive commissions as indicated. I acknowledge that producer may receive additional compensation and/or incentives based on other factors.

   ❑ 10% level commission ❑ Other ______________

   Group Contact Initials

Life and Disability Products:

10. It is agreed that the Group will maintain standard percentage of life and disability enrollment as indicated on the signed proposal.
11. If enrolled with Southern National Life Insurance Company, Inc., it is understood and agreed that the life and disability policies, if issued, shall include administrative provisions applicable to the life and disability insurance; that such administrative provisions shall be binding upon the Group/Policyholder and Southern National Life Insurance Company, Inc., subject to all of the provisions of the life and disability policies; and that this application shall form part of the contract to be issued by Southern National Life Insurance Company, Inc.
12. I recognize SNL Producer # _________ as the producer of record for my Group's life and disability benefit plan(s) and acknowledge that the producer may receive commissions as indicated below (G = Graded L = Level), please circle one. The Group/Policyholder expressly acknowledges that the

contract issued by Southern National Life Insurance Company, Inc. constitutes a contract solely between the Group/Policyholder and Southern National Life Insurance Company, Inc., that Southern National Life Insurance Company, Inc. is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the "Association" permitting Southern National Life Insurance Company, Inc. to use the Blue Cross and Blue Shield Service marks in the state of Louisiana and that Southern National Life Insurance Company, Inc. is not contracting as an agent of the Association.

❑ _____% G L Group Term Life		❑ _____% G L Voluntary Life
❑ _____% G L Short Term Disability	Group Contact	❑ _____% G L Voluntary Short and/or Long Term Disability
❑ _____% G L Long Term Disability	Initials	❑ _____% G L Voluntary High-Limit AD&D

I also acknowledge that producer may receive additional compensation and/or incentives based on other factors such as growth. The additional compensation may be from 0 to 4 percent, with an average of 2 percent.

All Products:

13. New employees who do not exercise the option to enroll self or dependents during their initial period of eligibility will be subject to the eligibility requirements stated in the Benefit Plan.
14. It is agreed that the effective date of the Benefit Plan of an employee's coverage will be subject to the approval of our home office.
15. All subscribers in the Group are full-time employees (30 hours per week minimum) or __________, except for retirees less than age sixty-five (65), unless the Company's records designate otherwise.
16. All information provided on this application, payroll records, and/or SUTA form is correct to the best of my knowledge.
17. The Group will submit to Our Membership & Billing Department, evidence of a Member's election of any applicable COBRA or other continuation of coverage within three (3) business days of the Group's receipt of signed continuation forms from the Member.
18. Group agrees that it was not formed primarily for purposes of buying medical, vision, dental, life and/or disability insurance.
19. Premiums must be paid in US dollars. Policyholder will be assessed a $25 NSF fee should its premium be paid with a check that is returned by the bank due to insufficient funds. If multiple payments are returned by the bank, Company may at its sole discretion refuse to reinstate coverage or may require group to pay by an alternate method.
20. In the event federal or state law requires Company to rebate a portion of any premium payment, Company will pay the rebate to the Group/Policyholder. Group/Policyholder will use or distribute rebates in accordance with law. Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligation under this section of the Group Health Benefit Plan.
21. Company will provide the Summary of Benefits and Coverage to the Group/Policyholder for distribution to Participants and Beneficiaries in accordance with law. Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligation under this section of the Group Health Benefit Plan.
22. If enrolled with Blue Cross and Blue Shield of Louisiana, on behalf of the Group, I hereby constitute and appoint the directors of Louisiana Health Service & Indemnity Company, present in person or by proxy given to another director(s), to vote, on behalf of the Group, at membership meetings on any matter on which policyholders are entitled to vote. **I acknowledge 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 this proxy is revoked, the premium may continue to be paid without affecting the revocation of the Group's coverage. I understand that any other policyholder may be designated a proxy by sending any form of writing to the Plan at P.O. Box 98029, Baton Rouge, Louisiana 70898-9029. I also hereby acknowledge that I am authorized by the Group to grant such proxy on behalf of the Group. **Check this block if you do not want to grant this proxy.** ❑
23. The Group will notify Our Membership & Billing Department of a Member's termination from medical and dental coverage no later than within the next billing cycle immediately following the billing cycle in which the Member (or any of the Member's Dependents) is terminated from the Group or eligibility for coverage ends. Company is under no obligation to refund any premium paid by Group or any Member because of the Group's failure to timely notify Company of a Member's or his/her Dependent's termination of coverage. Terminations notified or requested by Group beyond the period here provided will only be honored by Company prospectively after the date of receipt, and Group will be responsible for paying all corresponding premiums until the effective date of termination. All requests for termination of coverage, whether timely or not, will be subject to any other terms, conditions and legal requirements that may apply. Whenever the Group submits a request to Company to terminate a Member's coverage or that of any of Member's Dependents, the Group will be deemed to be making a representation that neither the Member nor his/her Dependent has made payments towards the cost of premiums for any coverage period beyond the date on which the Group desires the coverage to be terminated, and that no information was given or representation was made to the Member or his/her Dependent that would create an expectation that the individual would continue coverage beyond that date, except for legally required disclosures regarding any rights to COBRA or other mandated continuation coverage. In the event that the individual should have a right to continue coverage under COBRA or any similar mandate, the Group will be required to timely request the individual's termination of coverage under the regular process created by Company for such purpose, and to submit any election from the individual to continuation coverage in a separate process.
24. Company may request copies of the group's SUTA forms to determine that an employee is a "bona fide" employee even though wages may not be paid to the employee during the time the employee is not actually working.

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.

Group/Policyholder Signature ________________________________ Date ______________________________

Producer Signature ____________________________ Producer Number ________ Date ______________________________

BCBSLA Representative Signature ________________________________ Date ______________________________

Underwriter Approval ______________________________ Date ______________________________

Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice
Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@bcbsla.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

   Section 1557 Coordinator
   P. O. Box 98012
   Baton Rouge, LA 70898-9012
   225-298-7238 or 1-800-711-5519 (TTY 711)
   Fax: 225-298-7240
   Email: Section1557Coordinator@bcbsla.com

2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Blue Cross and Blue Shield of Louisiana is incorporated as Louisiana Health Service & Indemnity Company. HMO Louisiana, Inc., and Southern National Life Insurance Company, Inc., are subsidiaries of Blue Cross and Blue Shield of Louisiana. All three companies are independent licensees of the Blue Cross and Blue Shield Association.

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d’identification. Si vous souffrez d’une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.
إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫຼັງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔ سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید. مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)

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