



Health Plus of Louisiana
 Post Office Box 32625
 Shreveport LA 71130-2625
 www.wkhealthplus.com
 FAX TO (318) 676-3373

EMPLOYER USE ONLY	
COMPANY NAME	
LOC # / DEPT #	
EFFECTIVE DATE	
HR AUTHORIZATION	

1. PURPOSE

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> NEW HIRE | <input type="checkbox"/> OPEN/SPECIAL ENROLL | <input type="checkbox"/> ADDRESS CHANGE | <input type="checkbox"/> CONTINUATION/COBRA APPLICATION |
| <input type="checkbox"/> ADD DEPENDENT(S) | <input type="checkbox"/> TERM DEPENDENT(S) | <input type="checkbox"/> NAME CHANGE | <input type="checkbox"/> TERMINATION |

APPLICATION FOR

- | | | |
|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> HMO CHOICE | <input type="checkbox"/> VALUECHOICE HMO | <input type="checkbox"/> HDHP |
| <input type="checkbox"/> POS CHOICE | <input type="checkbox"/> VALUECHOICE POS | <input type="checkbox"/> SELECTCHOICE |

2. EMPLOYEE INFORMATION – Print legibly

Last Name		First Name		MI	Social Security #		Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address				City		State		Zip Code		<input type="checkbox"/> Single <input type="checkbox"/> Married
Height	Weight	Home Phone		Work Phone		Date of Hire		E-mail		

3. Have you or a Dependent had health insurance within 63 days? YES NO *If YES, attach HIPAA Certificate if not on current plan*

NOTICE—YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS NOT AUTHORIZED BY THIS PLAN.

4. FAMILY INFORMATION – Print legibly (if covered only)

Add/ Term	Last Name	First Name	Social Security #	Relationship to Employee	Date of Birth	Sex M/F	Height & Weight
<input type="checkbox"/> Add <input type="checkbox"/> Term	Spouse						
<input type="checkbox"/> Add <input type="checkbox"/> Term	Dependent 1						
<input type="checkbox"/> Add <input type="checkbox"/> Term	Dependent 2						
<input type="checkbox"/> Add <input type="checkbox"/> Term	Dependent 3						
<input type="checkbox"/> Add <input type="checkbox"/> Term	Dependent 4						
<input type="checkbox"/> Add <input type="checkbox"/> Term	Dependent 5						

- + If last names differ—ATTACH both Birth Certificate/Adoption Papers and Marriage License (for child) or Marriage License (for Spouse)
- + If any child provided above is 21 years old or older, proof of student status must be provided

5. OTHER INSURANCE INFORMATION – For those listed above

Will you or any family member be covered by other health insurance or Medicare **You** YES NO
AND Health Plus at the same time? If YES, then give other health insurance **Spouse** YES NO
 information below. If NO, then skip questions below. **Child(ren)** YES NO

Name	Relationship	Health Insurance Co. Name or Employer
Name	Relationship	Health Insurance Co. Name or Employer
Name	Relationship	Health Insurance Co. Name or Employer

Medicare Eligible? **You** Yes No Part A Part B due to: Kidney Failure Disability Over 65
Spouse Yes No Part A Part B due to: Kidney Failure Disability Over 65

IF YES, YOU MUST ATTACH A COPY OF YOUR MEDICARE CARD

PLEASE PRINT

First Name	MI	Last Name	Social Security Number
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HEALTH INFORMATION — Explain any “Yes” answers in complete detail below

1. Have you or any proposed dependent ever been declined or postponed for medical or life insurance with another insurer? If Yes, Why?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you or any proposed dependent now Pregnant? If Yes, Give: Due Date: [_____]	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you or any proposed dependent ever been diagnosed with Abnormal Blood Pressure? If Yes, Give: 1) Current B/P Reading: [_____] & 2) Date of Reading: [_____]	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you or any proposed dependent ever been diagnosed with High Cholesterol? If Yes, Give: 1) Date Diagnosed: [_____] & 2) Current Cholesterol Level: [LDL _____ HDL _____]	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you or any proposed dependent ever been diagnosed with Diabetes? If Yes, Give: 1) Date Diagnosed: [_____] & 2) Current Glucose Reading: [_____]	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you or any proposed dependent ever had any indication, diagnosis, consultation, treatment or taken any medication for:	
a. Asthma, allergies, sinus trouble, bronchitis, tuberculosis or other lung disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Osteoarthritis, rheumatoid arthritis, gout, or any bodily deformity or sciatica (<i>indicate body part affected and severity</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Coronary artery disease, heart attack, angioplasty, bypass, results of last EKG (<i>normal/abnormal</i>), rheumatic heart disease, mitral valve stenosis, arrhythmia, fibrillation, pacemaker, or stroke (<i>indicate any resulting paralysis</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Cancer (<i>indicate location, malignant/benign, surgery, treatment, remission</i>), cyst, growth, or tumor	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Kidney or urinary system disorder or kidney stones (<i>indicate how many stones, spontaneously passed, or lithotripsy</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Goiter, thyroid, or varicose veins (<i>indicate present or corrected</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Mental disorders, anxiety, depression, counseling, alcohol/drug treatment (<i>indicate time since abstinence and specific drug</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Irregular or excessive menstrual bleeding, “female disorder” (<i>indicate cause: menopausal, endometriosis, hysterectomy</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Gall stones, gall bladder, prostate hypertrophy (<i>give PSA level</i>), colon, hepatitis or liver disorder (<i>give cause, ALT reading</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Reflux, esophagitis, stomach/colon disorder, appendicitis, or ulcer (<i>give type</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Blood disorder/Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Back disorder, joint repair or replacement, muscular disease, or any other orthopedic problems (<i>give cause</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. Acquired Immune Deficiency Syndrome (AIDS) or related complex (ARC), any positive HIV test results, known AIDS/HIV exposure	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. Sleeplessness, sleep apnea (<i>indicate CPAP use</i>), headaches, migraines (<i>give frequency and severity</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
o. Organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No
p. Candidiasis (<i>yeast</i>), herpes-genital, ocular, shingles (<i>give frequency</i>), syphilis (<i>give stage</i>), gonorrhea, condylomata acuminata	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you or any proposed dependent, for any reason not stated above during the past 3 years:	
a. been hospitalized or were advised to be hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. had surgery or were advised to have surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. had any injury, illness, medical advice, medical attention, or treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. been advised to have any test which was not done?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are you or any proposed dependent currently taking or have taken any prescription medications in the past 12 months? If Yes, List Below: 1) Medications, 2) Dosage, & 3) Dates	

EXPLAIN “YES” ANSWERS TO ANY QUESTION — Use extra paper if necessary

Question #	Name of Family Member	Question #	Name of Family Member
Date of Onset/Treatment (Mo/Yr)	Date Ended (Mo/Yr) <input type="checkbox"/> Still Under Treatment	Date of Onset/Treatment (Mo/Yr)	Date Ended (Mo/Yr) <input type="checkbox"/> Still Under Treatment
Name of Condition(s) or Illness(es) Treated		Name of Condition(s) or Illness(es) Treated	
Treatment Rendered	Medication (if taken)/ Dosage	Treatment Rendered	Medication (if taken)/ Dosage
Treating Physician/Phone Number		Treating Physician/Phone Number	
Question #	Name of Family Member	Question #	Name of Family Member
Date of Onset/Treatment (Mo/Yr)	Date Ended (Mo/Yr) <input type="checkbox"/> Still Under Treatment	Date of Onset/Treatment (Mo/Yr)	Date Ended (Mo/Yr) <input type="checkbox"/> Still Under Treatment
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Question #	Name of Family Member	Question #	Name of Family Member
Date of Onset/Treatment (Mo/Yr)	Date Ended (Mo/Yr) <input type="checkbox"/> Still Under Treatment	Date of Onset/Treatment (Mo/Yr)	Date Ended (Mo/Yr) <input type="checkbox"/> Still Under Treatment
Name of Condition(s) or Illness(es) Treated		Name of Condition(s) or Illness(es) Treated	
Treatment Rendered	Medication (if taken)/ Dosage	Treatment Rendered	Medication (if taken)/ Dosage
Treating Physician/Phone Number		Treating Physician/Phone Number	

**IMPORTANT INFORMATION PLEASE READ CAREFULLY
AND SIGN BOTTOM FOR COVERAGE**

PLEASE PRINT

First Name	MI	Last Name	Social Security Number
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PRIVACY NOTICE

NEITHER THE U.S. BROKERS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW.

YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION.

Health Plus shall not obtain genetic information from a member, or from member's DNA sample, without first obtaining written consent from the member, or such member's representative, and such information shall not be used to terminate, restrict, limit or otherwise apply conditions to a member's coverage in accordance with Louisiana Revised Statute 22:213.7.

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.

The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements made by me on this application may invalidate my and/or my dependents' coverage subjecting that coverage to rescission. I understand that coverage will become effective only on the date specified by Health Plus after the application has been approved by Health Plus and after the first full premium has been paid. By signing this enrollment form, I hereby certify that all the information is true and correct.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give Health Plus any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or claim and for any analytical or research purposes or for Health Plus' medical management program. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. Finally, I agree on behalf of Us to comply with health Plus' case management or disease management programs. A photocopy of this authorization will be as valid as the original.

THIS SPACE BELOW MUST BE SIGNED FOR COVERAGE

Employee Signature X	Date Signed
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**TO BE COMPLETED IF HEALTH COVERAGE IS DECLINED
OR REFUSED BY AN ELIGIBLE EMPLOYEE OR FAMILY MEMBER**

Waiver of Contributory Group Benefits

All employees are required to submit a signed Member Application **or** this Waiver of Contributory Group Benefits form below when first eligible.

Employer	
Employee Name	Social Security Number

I have been given the opportunity to enroll myself and my dependents (if any) for coverage for which I am eligible under the group health plan provided through my employer. The advantages of this coverage have been explained to me, and I waive coverage as indicated below.

COVERAGE WAIVED FOR: Check all that apply

- Employee
- Spouse **PLEASE PRINT NAME OF SPOUSE** _____
- Child(ren) **PLEASE PRINT NAME(S) OF CHILD(REN)** _____

REASON FOR WAIVER: Check all that apply

- Coverage under spouse's health benefit plan
- Coverage under COBRA
- Do not desire health coverage
- Other **PLEASE PRINT OTHER REASON** _____

Neither I nor my dependents have been induced or pressured into declining coverage because of health status or related factors, but have waived such coverage(s) of our own free choice.

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in this Plan, provided that you request enrollment within thirty (30) days after your other coverage ends. In addition, if you have any new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption. Otherwise, coverage for yourself or your dependents under this plan may also be made during a future enrollment period.

SIGN HERE TO WAIVE COVERAGE

Signature of Employee Waiving Coverage	Date Signed
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