

Hosanna Christian Academy

New Hire Employee Packet (July 2011)

Welcome to Hosanna Christian Academy. We are excited to welcome you to our family. Successful completion of this packet will finalize your hiring process. Please follow these instructions. This packet contains forms that you must complete PRIOR to being paid.

1. Pages 1 and 2
 - a. Page 1 is the first of two background check & fingerprint forms.
 - i. Complete the BOTTOM portion of this form.
 - ii. This form requires a \$45.25 BUSINESS CHECK.
 - iii. Come to HCA and get this check from us.
 - b. Page 2 is the second of the background check & fingerprint forms.
 - i. Complete the MIDDLE portion of this form.
 - ii. This form requires a \$10.00 BUSINESS CHECK.
 - iii. Come to HCA and get this check from us.
 - c. You will receive two BUSINESS CHECKS from us made out to the State Police as stated above.
 - d. You will take these two checks along with the completed forms (pages 1 & 2) to the State Police.
 - i. 7919 Independent Blvd., Baton Rouge, LA 70806 (3 minutes from school)
 - ii. Monday – Friday, 8am – 4pm
 - e. State Police will send us an e-mail confirming that you have a clean background check.
2. Pages 3 – 4 (Federal Tax Forms)
3. Page 5 (State Tax Form)
4. Pages 6 – 10 (I-9 Federal Employment Form)
 - a. Please pay close attention to the “Lists of Acceptable Documents” on page 10.
 - b. We MUST have accurate forms of personal identification as indicated on page 10. No substitutions!
5. Pages 11 – 16 (Blue Cross/Shield of LA Plan Information & Enrollment Forms)
 - a. All fulltime employees MUST complete these forms.
 - b. If you want health coverage, complete sections A, B, C, E (if adding spouse/family), G, H, & I.
 - c. If you do NOT want health coverage, complete only section B, the “Waive of Coverage” in section C, and section I.
 - d. In Section A – Circle HMO Plan # 56 or #65.
 - e. 2011 – 2012 Insurance Premiums Chart

'11- '12 Health Insurance Premiums EMPLOYEE PORTION after HCA Subsidy	Employee ONLY	Employee & Children	Employee & Spouse	Employee & Family
Plan #56 – HCA Partially Subsidized Plan	\$77.77	\$469.74	\$537.17	\$919.43
Plan #65 – HCA Fully Paid, NO Cost for YOU Plan	FREE	\$341.45	\$398.48	\$721.80

6. Page 17 (FREE Life Insurance Form)
7. Please contact Madeleine Felps with any additional questions.



SUBMIT TO:

Louisiana State Police
Bureau of Criminal Identification and Information
P.O. Box 66614 (Mail Slip A-6)
Baton Rouge, LA 70896

THE FEE FOR PROCESSING A STATE BACKGROUND CHECK IS \$26. FOR FBI PROCESSING, WHERE AUTHORIZED OR REQUIRED, THERE IS AN ADDITIONAL \$19.25 FEE. (Cashier Check, Business Check or Money Order)

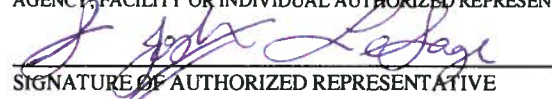
****FORMS MUST BE FILLED OUT IN INK AND BE REVIEWED BY SUBMITTING AGENCY/INDIVIDUAL FOR ACCURACY**
****FINGERPRINTS ARE NECESSARY FOR A POSITIVE IDENTIFICATION******

****PLEASE PRINT****

Hosanna Christian Academy
AGENCY, FACILITY OR INDIVIDUAL

S. Josh LeSage, Administrator
AGENCY, FACILITY OR INDIVIDUAL AUTHORIZED REPRESENTATIVE

8850 Goodwood Blvd.
MAILING ADDRESS


SIGNATURE OF AUTHORIZED REPRESENTATIVE

Baton Rouge LA 70810
CITY STATE ZIP CODE

(225) 926 - 4885
AGENCY, FACILITY OR INDIVIDUAL PHONE NUMBER

SJL@hcablazers.org
AGENCY, FACILITY OR INDIVIDUAL E-MAIL ADDRESS

Request For: (pick one only)

- ALCOHOL AND BEVERAGE COMMISSION
- ALCOHOL BEVERAGE OUTLET
- AUTHORIZED AGENCY
- BOARD OF EXAMINERS OF PSYCHOLOGIST
- BOARD OF NURSING HOME ADMINISTRATORS
- CASA
- COURT ORDER ADOPTION
- CRIMINAL JUSTICE EMPLOYEE
- DAYCARE
- DENTISTRY BOARD
- DEPARTMENT OF INSURANCE
- DCFS ABUSE/NEGLECT INVESTIGATION
- DCFS CARETAKER
- DCFS FOSTER/ADOPTIVE
- DCFS PERSONNEL
- EMPLOYERS
- FIREFIGHTERS
- FIRE MARSHAL
- HEALTH CARE PROVIDER (Non Licensed)
- JUVENILE DETENTION CENTER
- LA PHYSICAL THERAPY BOARD
- LA STATE BOARD SOCIAL WORK EXAMINERS
- MANUFACTURED HOUSING

- MEDICAL EXAMINERS
- OFFICE OF FINANCIAL INSTITUTIONS
- OFFICE OF PUBLIC HEALTH
- PHARMACY BOARD
- POST SECONDARY EDUCATION
- PRACTICAL NURSING
- PRIVATE ADOPTION
- PRIVATE INVESTIGATORS
- PRIVATE SECURITY
- PUBLIC HOUSING
- PUBLIC TAG AGENT
- REGISTERED NURSING
- RELIGIOUS ACTIVISTS
- RIGHT TO REVIEW
- RIVERBOAT PILOTS
- SCHOOL
- TAXI DRIVERS
- TESS WINDOW TINT
- USED MOTOR VEHICLE COMMISSION
- VENDOR
- VOLUNTEERS W/YOUTH SERVING ORG
- WHOLESALE DRUG DISTRIBUTORS
- WORKING WITH CHILDREN

APPLICANTS FULL NAME: _____
****PRINT - USE INK**** LAST FIRST MIDDLE
{INCLUDE MAIDEN NAME & PREVIOUS MARRIED NAMES IF APPLICABLE}

APPLICANTS SIGNATURE: _____

APPLICANTS SOCIAL SECURITY # _____ DATE OF BIRTH: __ / __ / __

ID or DRIVERS LICENSE # _____ & STATE _____ RACE _____ SEX _____

POSITION OR LICENSE APPLIED FOR _____

AUTHORIZATION TO DISCLOSE CRIMINAL HISTORY RECORDS INFORMATION

By my signature above, I hereby authorize the Louisiana State Police to release all pertinent criminal record information maintained in their files, other states files, or the FBI files (if applicable) which may confirm or deny my eligibility with the facility or agency named above. **DPSSP 6696**

Form W-4 (2011)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using

Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A _____
B	Enter "1" if: <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B _____
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C _____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D _____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E _____
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit	F _____
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children 	G _____
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) For accuracy, complete all worksheets that apply. <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. 	H _____

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 <h1 style="margin: 0;">2011</h1>
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶		7 _____
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (This form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)
		10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet only if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2011 itemized deductions... 2 Enter: { \$11,600 if married filing jointly... } 3 Subtract line 2 from line 1... 4 Enter an estimate of your 2011 adjustments to income... 5 Add lines 3 and 4... 6 Enter an estimate of your 2011 nonwage income... 7 Subtract line 6 from line 5... 8 Divide the amount on line 7 by \$3,700... 9 Enter the number from the Personal Allowances Worksheet... 10 Add lines 8 and 9...

Two-Earners/Multiple Jobs Worksheet (See Two earners or multiple jobs on page 1.)

Note. Use this worksheet only if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1... 2 Find the number in Table 1 below that applies to the LOWEST paying job... 3 If line 1 is more than or equal to line 2, subtract line 2 from line 1... Note. If line 1 is less than line 2, enter "-0-" on Form W-4... 4 Enter the number from line 2 of this worksheet... 5 Enter the number from line 1 of this worksheet... 6 Subtract line 5 from line 4... 7 Find the amount in Table 2 below that applies to the HIGHEST paying job... 8 Multiply line 7 by line 6... 9 Divide line 8 by the number of pay periods remaining in 2011...

Table 1

Table 2

Table with 8 columns: Married Filing Jointly, All Others, Married Filing Jointly, All Others. Rows show wage brackets and corresponding withholding amounts.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



Purpose: Complete form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions: Employees who are subject to state withholding should complete the personal allowances worksheet indicating the number of withholding personal exemptions in Block A and the number of dependency credits in Block B.

- Employees must file a new withholding exemption certificate within 10 days if the number of their exemptions decreases, except if the change is the result of the death of a spouse or a dependent.
- Employees may file a new certificate any time the number of their exemptions increases.
- Line 8 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willful failure to supply information that would reduce the withholding exemption.

This form must be filed with your employer. If an employee fails to complete this withholding exemption certificate, the employer must withhold Louisiana income tax from the employee's wages without exemption.

Note to Employer: Keep this certificate with your records. If you believe that an employee has improperly claimed too many exemptions or dependency credits, please forward a copy of the employee's signed L-4 form with an explanation as to why you believe that the employee improperly completed this form and any other supporting documentation. The information should be sent to the Louisiana Department of Revenue, Criminal Investigations Division, PO Box 2389, Baton Rouge, LA 70821-2389.

Block A

- Enter "0" to claim neither yourself nor your spouse. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim yourself if you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household.
- Enter "2" to claim yourself and your spouse.

A.

Block B

- Enter the number of dependents, not including yourself or your spouse, whom you will claim on your tax return. If no dependents are claimed, enter "0."

B.

Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form L-4 Louisiana Department of Revenue	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2>
--	--

1. Type or print first name and middle initial	Last name	
2. Social Security Number	3. <input type="checkbox"/> No exemptions or dependents claimed <input type="checkbox"/> Single <input type="checkbox"/> Married	
4. Home address (number and street or rural route)		
5. City	State	ZIP
6. Total number of exemptions claimed in Block A	6.	
7. Total number of dependents claimed in Block B	7.	
8. Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount.	8.	

I declare under the penalties imposed for filing false reports that the number of exemptions and dependency credits claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature	Date
----------------------	------

The following is to be completed by employer.

9. Employer's name and address	10. Employer's state withholding account number
--------------------------------	---

Instructions

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present

in **Section 2** evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers (Form M-274)*. You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

- A.** If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- B.** If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- C.** If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B; and:
1. Examine any document that reflects the employee is authorized to work in the United States (see List A or C);
 2. Record the document title, document number, and expiration date (if any) in Block C; and
 3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3**.

What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification (To be completed and signed by employee at the time employment begins.)

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) _____
- An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year)

Employee's Signature _____ Date (month/day/year) _____

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification (To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____				

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)		Date (month/day/year)

Section 3. Updating and Reverification (To be completed and signed by employer.)

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
-----------------------------	--

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____	Document #: _____	Expiration Date (if any): _____
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.		
Signature of Employer or Authorized Representative		Date (month/day/year)

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

**Documents that Establish Both
Identity and Employment
Authorization**

LIST B

**Documents that Establish
Identity**

LIST C

**Documents that Establish
Employment Authorization**

OR

AND

1. U.S. Passport or U.S. Passport Card	1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa	2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
4. Employment Authorization Document that contains a photograph (Form I-766)	3. School ID card with a photograph	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form	4. Voter's registration card	
	5. U.S. Military card or draft record	
	6. Military dependent's ID card	5. Native American tribal document
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	6. U.S. Citizen ID Card (Form I-197)
	9. Driver's license issued by a Canadian government authority	
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI	For persons under age 18 who are unable to present a document listed above:	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI	10. School record or report card	8. Employment authorization document issued by the Department of Homeland Security
	11. Clinic, doctor, or hospital record	
	12. Day-care or nursery school record	

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

65
 ↓

Hosanna First Assembly – Free Plan*

POS \$35 PCP CO-PAY PLAN #65 1/1/2010			
	NETWORK	OUT-OF-NETWORK	DEPENDENT OUT-OF-AREA
Calendar Year Deductible - Aggregate	\$1,000 Individual / \$3,000 Family	\$2,500 Individual / \$7,500 Family	\$250 Individual / \$750 Family
Out-of-Pocket Calendar Year Maximum	\$3,500 Individual / \$7,000 Family Aggregate (Excludes Deductible)	\$6,000 Individual / \$12,000 Family (Excludes Deductible)	\$1,000 Individual / \$3,000 Family (Excludes Deductible)
Lifetime Maximum	\$5 Million		
OFFICE VISITS AND PREVENTIVE CARE			
Office Visits	\$35 Co-pay Per Visit	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Specialist Office Visits	\$50 Co-pay Per Visit	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Wellness Visits	\$35 Co-pay Per Visit rendered by PCP \$50 Co-pay Per Visit rendered by Specialist	Deductible then 60/40 Coinsurance*	100% for Eligible Physical Exams
Vision Care	\$50 Co-pay (1 Every 24 Mos.)	\$50 Co-pay (1 Every 24 Mos.)	\$50 Co-pay (1 Every 24 Mos.)
Lab & Low Tech Xray (Incl. Independent lab or Free-standing Imaging)	100%	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
High Tech X-ray Services (Incl. Independent lab or free-standing Imaging)	Deductible then 80/20 Coinsurance	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
OUTPATIENT SERVICES PERFORMED AT AN OUTPATIENT FACILITY			
Facility Charges	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Professional Services	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Lab and X-ray	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
INPATIENT SERVICES			
Hospital	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Professional Services	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
MENTAL HEALTH and SUBSTANCE ABUSE SERVICES			
Mental Health			
- Inpatient	100%	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
- Outpatient	\$50 Co-pay per visit		
Substance Abuse			
- Inpatient	100%	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
- Outpatient	\$50 Co-pay per visit		
BENEFITS THAT REQUIRE AUTHORIZATION (does not include list of outpatient services or drugs requiring authorization)			
Organ and Tissue Transplants	Covered as any other illness	Not Available	Deductible then 80/20 Coins.; \$50,000 Lifetime
Skilled Nursing Facility (90 day Maximum Per Calendar Year)	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Home Health (60 Visit Max Per Calendar Year)	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Hospice (180 Day Max)	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
OTHER COVERED SERVICES			
Prescription Drug Co-payments Refer to the contract for applicable supply limitations Retail – up to 30 day supply Mail Order – up to 90 day supply [Prescription Drug Deductible]	Generic / Preferred Brand / Non-Preferred Brand / Multi-Source / Injectables (available options shown below) -Contraceptives Included - \$7 / \$30 / \$55 / \$70 / \$50 \$21 / \$90 / \$165 / \$210 / \$150 [\$100 per Calendar Year]		
Prenatal Visits and Delivery (Opt. for Grps 14 emps. or less)	\$50 Co-pay Per Pregnancy in addition to any related Inpatient Hospital Co-pay	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Emergency Room	\$100 Co-pay/Visit Waived if Admitted	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Rehabilitative Speech Therapy (up to \$2,500 per Cal Yr.) – Excludes Inpatient	\$35 Co-pay Per Visit	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Physical/Occupational Therapy (up to \$4,500 combined per year)-Excludes Inpatient	\$35 Co-pay Per Visit	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Urgent Care Center	\$50 Co-pay Per Visit	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Ambulance	\$50 Co-pay Per Day Per Provider	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Prosthetic Limbs-\$50,000 cap per limb per year	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*
Durable Medical Equipment (\$15,000 cal yr max)	Deductible then 80/20 Coinsurance*	Deductible then 60/40 Coinsurance*	Deductible then 80/20 Coinsurance*

All benefits based on allowable charges. *Accrues to the Out-of-Pocket Maximum
 01100 00101 1/10R This is only an outline all benefits are subject to the terms and conditions of the contract. In the case of a discrepancy, the contract will prevail.

12

#56
 HCA Subsidized Plan

Hosanna First Assembly- Current Plan

POS \$25 PCP CO-PAY PLAN #56 1/1/2010			
	NETWORK	OUT-OF-NETWORK	DEPENDENT OUT-OF-AREA
Calendar Year Deductible	None	\$1,750 Individual / \$5,250 Family Aggregate	\$250 Individual / \$750 Family Aggregate
Out-of-Pocket Calendar Year Maximum	\$2,000 Individual / \$4,000 Family Aggregate	\$4,000 Individual / \$8,000 Family Aggregate (Excludes Deductible)	\$1,000 Individual / \$3,000 Family Aggregate (Excludes Deductible)
Lifetime Maximum	\$5 Million		
OFFICE VISITS AND PREVENTIVE CARE			
Office Visits	\$25 Co-pay Per Visit	70/30 Coinsurance*	80/20 Coinsurance*
Specialist Office Visits	\$40 Co-pay Per Visit	70/30 Coinsurance*	80/20 Coinsurance*
Wellness Visits	\$25 Co-pay Per Visit rendered by PCP \$40 Co-pay Per Visit rendered by Specialist	70/30 Coinsurance*	100% for Eligible Physical Exams
Vision Care	\$40 Co-pay (1 Every 24 Mos.)	\$40 Co-pay (1 Every 24 Mos.)	\$40 Co-pay (1 Every 24 Mos.)
OUTPATIENT SERVICES			
Rehabilitative Speech Therapy (up to \$2,500 per Cal Yr.)	\$25 Co-pay	70/30 Coinsurance*	80/20 Coinsurance*
Physical and Occupational Therapy (up to \$4,500 combined per year)	\$25 Co-pay Per Visit	70/30 Coinsurance*	80/20 Coinsurance*
X-ray & Lab	No Co-pay, 100%	70/30 Coinsurance*	80/20 Coinsurance*
Surgery Facility Charge	\$300 Co-pay Per Surgery*	70/30 Coinsurance*	80/20 Coinsurance*
Surgery Professional Charge	No Co-pay; 100%*	70/30 Coinsurance*	80/20 Coinsurance*
INPATIENT SERVICES			
Hospital	\$300 Co-pay Per Day for 3 Days*	70/30 Coinsurance*	80/20 Coinsurance*
Professional Services	No Co-pay; 100%	70/30 Coinsurance*	80/20 Coinsurance*
MENTAL HEALTH and SUBSTANCE ABUSE SERVICES			
Mental Health - Inpatient	\$300 Co-pay Per Day for 3 Days*	70/30 Coinsurance*	80/20 Coinsurance*
- Outpatient	\$40 Co-pay Per Visit		
Substance Abuse - Inpatient	\$300 Co-pay Per Day for 3 Days*	70/30 Coinsurance*	80/20 Coinsurance*
- Outpatient	\$40 Co-pay Per Visit		
BENEFITS THAT REQUIRE AUTHORIZATION (does not include list of outpatient services or drugs requiring authorization)			
Organ and Tissue Transplants	Covered as any other illness	Not Available	80/20 Coins*; \$250,000 Lifetime
Skilled Nursing Facility (90 day Max Per Calendar Year)	No Co-pay, 100%	70/30 Coinsurance*	80/20 Coinsurance*
Home Health Care (60 Visit Max Per Cal Year)	No Co-pay, 100%	70/30 Coinsurance*	80/20 Coinsurance*
Hospice (180 Day Max)	No Co-pay, 100%	70/30 Coinsurance*	80/20 Coinsurance*
OTHER COVERED SERVICES			
[Prescription Drug Copayments Refer to the contract for applicable supply limitations Retail - up to 30 day supply Mail Order - up to 90 day supply [Prescription Drug Deductible]	Generic / Preferred Brand / Non-Preferred Brand / Multi-Source / Injectables (available options shown below) -Contraceptives Included - \$7 / \$30 / \$55 / \$70 / \$50 \$21 / \$90 / \$165 / \$210 / \$150 \$100 per Calendar Year		
Prenatal Visits and Delivery (Opt. for Gyps 14 emps. or less)	\$40 Co-pay Per Pregnancy in addition to the Inpatient Hospital Co-pay for any related hospitalization	70/30 Coinsurance*	80/20 Coinsurance*
Emergency Room	\$100 Co-pay/Visit Waived if Admitted	70/30 Coinsurance*	80/20 Coinsurance*
Urgent Care Center	\$50 Co-pay Per Visit	70/30 Coinsurance*	80/20 Coinsurance*
Ambulance	\$50 Co-pay Per Trip	70/30 Coinsurance*	80/20 Coinsurance*
Prosthetic Limbs up to \$50,000 per limb per year	80/20 Coinsurance*	70/30 Coinsurance*	80/20 Coinsurance*
Durable Medical Equipment (15,000 cal yr max)	80/20 Coinsurance*	70/30 Coinsurance*	80/20 Coinsurance*

All benefits based on allowable charges. *Accrues to the Out-of-Pocket Maximum ** All in Network Physician Inpatient Medical Visits are Paid at 100%
 01100 00101 1/10R This is only an outline all benefits are subject to the terms and conditions of the contract

13

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 (Individual/Spouse)
- Health Plan (Individual/Spouse)
- Blue Cross/Blue Shield

HMO Louisiana, Inc.

- HMO (Plan #) 56 or 65
- PPO (Individual/Spouse)
- Blue Cross/Blue Shield

LBI

- Southern National Life Insurance Company, Inc.
- Individual Plan
- COBRA from Prior Employer
- VA Eligibility
- Medicare
- Medicaid
- Tri-Care
- Other

SECTION B - EMPLOYEE INFORMATION

ENROLLEE'S LAST NAME	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	OTHER (explain below)		RETIRED	YES	NO	EMPLOYER NAME
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> OTHER			<input type="checkbox"/> YES <input type="checkbox"/> NO			

SECTION C - ENROLLMENT EVENTS

ENROLLMENT

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)
- Dental: Employee Only Employee & Spouse Employee & Dependent Child(ren)
- Life: Employee Only Employee & Spouse Employee & Dependent Child(ren)

CHANCE (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 (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 HMO 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

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

DEPENDENT'S FULL NAME (LAST, FIRST, MI)
 (Please circle the appropriate answer)

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.)

SOCIAL SECURITY NUMBER

BIRTHDATE

LIVES WITH YOU IF "NO" GIVE ADDRESS/LOCATION**

MENTALLY OR PHYSICALLY INCAPACITATED***

OUT OF AREA DEPENDENT/STUDENT

E	C	D	SPOUSE	<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE	N/A	N/A	<input type="checkbox"/> YES <input type="checkbox"/> NO
E	C	D	<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> STEPDAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
E	C	D	<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> STEPDAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
E	C	D	<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> STEPDAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
E	C	D	<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> STEPDAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
E	C	D	<input type="checkbox"/> SON <input type="checkbox"/> STEPSON <input type="checkbox"/> STEPDAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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 Other Group? Yes No If yes to either give: _____ Policyholder _____ Insurance Company _____

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

If yes, complete the information on the right.

If more than one prior carrier, please provide a certificate of coverage from other carrier(s).

List Members Covered	Coverage Start Date	Coverage End Date	Prior Insurance Carrier and Policy Number	Type of Coverage (Refer to Instruction Page)
				<input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit
				<input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit
				<input type="checkbox"/> Comprehensive <input type="checkbox"/> Limited Benefit
				<input type="checkbox"/> Comprehensive <input type="checkbox"/> 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
	<input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Part D	A. / / B. / / C. / / D. / /	A. _____ B. _____ C. _____ D. _____
	<input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 8. Abnormal blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Any type of cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 9. Heart trouble? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Any blood disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 10. Tuberculosis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. A stroke (CVA)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 11. Other lung problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Circulatory problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 12. HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Epilepsy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 13. Hepatitis or a liver disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Rheumatic fever? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

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

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

MISCELLANEOUS:

- | | | | | | |
|--|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| 39. Are you expecting a biological child within the next 9 months (male or female applicant)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 43. Have you, or anyone on this application, ever had any health insurance postponed, rated, ridered, declined, cancelled, or had reinstatement refused? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 40. Have you, or anyone on this application, used tobacco in any form within the last 12 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 41. Are you presently taking medications? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

The United States Life Insurance Company in the City of New York
New York, New York

Administrative Office: Client Services 3-A, 3600 Route 66, P.O. Box 1583, Neptune, NJ 07754-1583
Phone: 1-800-346-7692 Fax: 1-732-922-7604

Completing Your GROUP ENROLLMENT FORM 1. Fully complete each section 2. Sign and date Refusal/Authorization Section, as needed.				Group Policy No.(s)		<input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> CHANGE IN ENROLLMENT			
1. PERSONAL DATA: (Must always be completed)									
Division No.		Class	Social Security No.			Last Name		First Name	Initial
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	MM	DD	YY	Street Address		City	State	Zip Code
Name of Employer				Location			Salary \$		Per
Occupation			Title		Date of Full-Time Employment	MM	DD	YY	No. Hours Worked Per Week <input type="checkbox"/> Union <input type="checkbox"/> NonUnion
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				Dependent Children		No <input type="checkbox"/>	Yes <input type="checkbox"/>	If Yes, # _____	
2. ENROLLMENT									
If enrolling for Dental or Vision benefits, list name, relationship to you, and date of birth for each dependent to be insured. PLEASE LIST ADDITIONAL DEPENDENTS ON A SEPARATE SHEET. Give policy number, name and address of current employer's prior group insurance carrier, if you and your dependents were insured. Indicate your effective and termination dates of coverage also.									
Name	Relationship	Date of Birth	Self	Sp. Ch.	MM/DD/YY	Sex			
SELF	X								
3. Supplemental Life Benefit: If this benefit is a plan option and you wish to enroll for Supplemental Life coverage, please indicate									
The amount for: Employee \$ _____				Dependent \$ _____					
4. Beneficiary Designation: as is									
EX: MARY A. JONES, WIFE		First Name	Initial	Last Name		Relationship			
NOT MRS. JOHN JONES									
5. REFUSAL OF COVERAGE: (Note: Benefits provided on a non-contributory basis cannot be refused)									
I was given the opportunity to enroll in this plan for group insurance offered by my employer/association and insured by UNITED STATES LIFE.									
I am refusing: <input type="checkbox"/> LTD <input type="checkbox"/> STD <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Dependent Life <input type="checkbox"/> Supplemental Life/AD&D <input type="checkbox"/> All coverages offered		Dental: <input type="checkbox"/> Employee & Dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> All Dependents		Vision: <input type="checkbox"/> Employee & Dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> All Dependents					
MUST ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD COVERAGE:									
Are you or your dependents now covered by any other group plan?				<input type="checkbox"/> YES <input type="checkbox"/> NO		(Your dependent(s) may be insured by this Plan even if they are insured elsewhere)			
If Yes: Policyholder's Name _____				Carrier _____					
I understand that if I am refusing insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of the other applicable insurance plan.									
If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage.									
I must furnish, at my expense, evidence of insurability satisfactory to United States Life if I later wish to enroll in any other coverage that is now being refused.									
DATE OF REFUSAL _____				SIGNATURE IF REFUSING ANY COVERAGE _____					
*IF REFUSING ALL COVERAGES, IT IS NOT NECESSARY TO COMPLETE THE REMAINDER OF THIS FORM.									
6. AUTHORIZATION:									
• I hereby certify that all information furnished is true to the best of my knowledge. • I request group insurance for which I am or may become eligible. • If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contributions in advance from wages due me, for remittance to The United States Life Insurance Company in the City of New York.				• I designate the beneficiary named on this form to receive the proceeds, if any, payable upon my death. • If dental care or health care is provided by a participating provider, all benefits will be paid directly to the provider by United States Life. • I authorize any insurer or employer or any consumer reporting agency acting on its behalf to give to United States Life information about me. Such information will pertain to my employment or other insurance coverage.					
DATE SIGNED _____				APPLICANT'S SIGNATURE _____					