

NAME	Date of Birth	Dependent Relationship to Subscriber (son, daughter, step-son, etc)	Coverage For: H-Health D- Dental	Coverage Effective Date M/D/Y	Coverage Termination Date M/D/Y	<i>If Group Policy.</i> Date waiting period/affiliation period began M/D/Y (if any) or N/A	<i>If Individual Policy,</i> Date a Substantially Complete Application Submitted M/D/Y or N/A
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SECTION 3: AUTHORIZATION & CERTIFICATION BY SUBSCRIBER

I authorize Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. to verify all information provided with my prior carriers or employers. I attest that the information given on this form is accurate and true to my knowledge, and that I will refund immediately any monies paid in error by Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. as a result of misrepresented information on this form.

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.

Subscriber Signature _____ Date _____