



BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

ADDITIONAL INFORMATION SEND BACK NOTIFICATION

NOTE TO APPLICANT: We are returning the attached application because it indicates that you are enrolling outside of your group plan's eligibility. For reconsideration, your enrollment status must be verified. Please complete this form and return it with your application.

MM . DD YY

- Marriage, date of marriage _____ / _____ / _____
- Birth of child, date of birth _____ / _____ / _____
- Adoption, date or placement of adoption _____ / _____ / _____
- Loss of other coverage due to:
 - Divorce
 - Death
 - Termination of employment or reduction in work hours
 - Employer contributions for coverage ended
 - Other, please explain: _____

Date other coverage ended _____ / _____ / _____

- The full COBRA or Louisiana State Continuation Coverage period is exhausted _____ / _____ / _____
- I was previously denied group coverage for medical reasons. Please indicate approximate date of denial.
 _____ / _____ / _____

Other/Remarks: _____

GROUP NUMBER _____

DEPARTMENT _____

APPLICANT SOCIAL SECURITY NUMBER _____

EMPLOYER GROUP NAME _____

PRINT NAME _____

SIGNATURE OF APPLICANT _____

DATE _____