

Applying for a BlueCross BlueShield Plan is Simple

Just Follow 3 Easy Steps...

Step 1 Print the application and complete in black ink.

Step 2 Call or fax in to pre-screen your application

Step 3 Mail or fax the application with first months payment to the address below.

To assist you with completing the application here is a checklist:

___ On Family Applications BlueCross requires the oldest spouse to be the applicant.

___ Medical Information pages: all medical questions must be answered; please provide thorough details to every "yes" answer. If additional space is needed, list on a separate sheet and attach to the application. Please provide complete addresses of doctors where requested, attach an additional sheet if necessary.

___ Choose your first month payment option:

1. Payment by Credit Card – application can be faxed in.
2. Check payable to BlueCross – mail in with the application.

___ Maternity coverage is only available on the Premier plans and only as an optional rider.

Conditioned Authorization Form

___ Every family member over the age of 18 must sign this form

Please call with any questions; our office hours are 9am – 9pm Monday thru Friday

404-575-1960

800-910-1507

404-575-1967 fax

Once the application is complete, please call us or fax in, so that we may pre-screen it for detail and completeness before mailing it to us. After our review is complete, please mail the application with chosen payment option to:

HealthPlanStore
817 West Peachtree Street
Suite 915
Atlanta, GA 30308



Georgia Individual Enrollment Application



Please complete in blue or black ink only. Do not write in shaded areas, these are for internal use only.

Section A – Coverage Information

Application Type (select one): Change BCBSGa Individual policy coverage Add dependent(s) to current coverage
 New Coverage Policy No. _____ Policy No. _____

Effective date requested: If your application is approved your coverage can start on any day of the month as early as the date you signed your application providing we receive it within 10 days of that date. We will notify you of your actual effective date in writing.

Please choose the date you would like your coverage to start: ____ / ____ / ____ **MM/DD/YYYY**

Section B – Applicant Information (Applicant must be oldest adult member.)

| | | | |
|-----------|------------|----|-------------------------|
| Last Name | First Name | MI | Social Security Number* |
|-----------|------------|----|-------------------------|

Home Address (street and P.O. Box if applicable)

| | | | |
|------|-------|-----|--------|
| City | State | Zip | County |
|------|-------|-----|--------|

Billing Address (street and P.O. Box if different from above)

| | | | |
|------|-------|-----|--------|
| City | State | Zip | County |
|------|-------|-----|--------|

| | | | | | |
|--|-----------------------|--------|------------|-----|----------------------|
| Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner | Height (Ft./In.) / | Weight | Sex M F | Age | Date of Birth / / |
|--|-----------------------|--------|------------|-----|----------------------|

| | | |
|--------------------------------|--------------------------------|--|
| Daytime Phone Number () | Evening Phone Number () | E-mail* If possible, do you want E-mail notification? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--------------------------------|--------------------------------|--|

| | |
|--|---|
| Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | Language Choice (<i>For statistical purposes only.</i>) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Korean <input type="checkbox"/> Chinese (C/M) |
|--|---|

Section C – Spouse or Domestic Partner Information

| | | | |
|-----------|------------|----|-------------------------|
| Last Name | First Name | MI | Social Security Number* |
|-----------|------------|----|-------------------------|

| | | | | | |
|---|-----------------------|--------|------------|-----|----------------------|
| Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner | Height (Ft./In.) / | Weight | Sex M F | Age | Date of Birth / / |
|---|-----------------------|--------|------------|-----|----------------------|

| | |
|--|--|
| Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | Language Choice (Optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Korean <input type="checkbox"/> Chinese (C/M) |
|--|--|

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary.)

If this is an application for a Family Contract, list all eligible dependents. This includes all unmarried, dependent children, stepchildren, or legally adopted children under age 19 or up to the age of 26 if a full-time student, or as otherwise mandated by state law. List dependents in order of age, beginning with the oldest.

| First, MI (last name if different) | Social Security Number* | Sex | Age | Date of Birth mm/dd/yyyy | Height Ft. / In. | Weight Lbs. | Full-Time Student? |
|---------------------------------------|----------------------------|-----|-----|-----------------------------|---------------------|----------------|-----------------------|
| | | M F | | / / | / | | Y N |
| | | M F | | / / | / | | Y N |
| | | M F | | / / | / | | Y N |
| | | M F | | / / | / | | Y N |
| | | M F | | / / | / | | Y N |

Are all dependent children legal residents of the United States and residents of the state in which you are applying for coverage? Yes No

Has any person listed on this application lived (not traveled) outside the U.S. for the past 3 consecutive months? Yes No

**This information is used for internal purposes only.*

Section H – Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare? Yes No

If yes, give name. _____

Do you currently have health care coverage? Yes No

Did you or your eligible dependents have creditable coverage within the past 63 days? YES NO (you may be eligible for preexisting credit).

The following information must be completed in order for credit to be given. Please provide the previous 24 months of coverage.

| | |
|---|--------------------------|
| Name(s) of covered persons. If the whole family, simply write ALL in space below. | Identification Number(s) |
|---|--------------------------|

| | |
|---|-------------------------|
| Name and phone number of prior carrier(s) | Reason for cancellation |
|---|-------------------------|

| | | |
|--|----------------------------|-------------------------------|
| Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual | Effective Date of Coverage | Cancellation Date of Coverage |
|--|----------------------------|-------------------------------|

Will you be canceling this coverage if approved for Blue Cross Blue Shield of Georgia coverage? Yes No

Complete this section if you've had more than one carrier in the last 24 months (attach a separate sheet if necessary).

| | |
|---|--------------------------|
| Name(s) of covered persons. If the whole family, simply write ALL in space below. | Identification Number(s) |
|---|--------------------------|

| | |
|---|-------------------------|
| Name and phone number of prior carrier(s) | Reason for cancellation |
|---|-------------------------|

| | | |
|--|----------------------------|-------------------------------|
| Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual | Effective Date of Coverage | Cancellation Date of Coverage |
|--|----------------------------|-------------------------------|

Will you be canceling this coverage if approved for Blue Cross Blue Shield of Georgia coverage? Yes No

Section I – Health History (IMPORTANT: This section has two steps)

If you have questions about how to complete this application call your agent or Customer Service at 1-800-718-8831.

STEP 1: Health history questions must be answered by each/every person applying for coverage.**Health History Questionnaire — All questions must be answered or the application will be returned.**

GIVE COMPLETE DETAILS IN STEP 2 (page 6) FOR ALL QUESTIONS ANSWERED “YES”.

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. We are relying on the information you provide to determine whether you are eligible for coverage. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician(s) to clarify your specific condition. We have the right to review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, do not assume we will review all of your medical records before approving your application. If we issue coverage to you and later discover that you intentionally misrepresented or omitted information you knew in response to a question we may rescind your coverage, even after it has been issued. This means that you may lose your health benefits including coverage for treatment already received. Rescission may occur even if we review your medical records or seek medical confirmation of your health information as part of processing your application. Even if you currently have health insurance coverage or had prior coverage with Blue Cross Blue Shield of Georgia, you must fully disclose and answer all health history questions.

Note: Please make a copy of the signed application for your records prior to submitting to Blue Cross Blue Shield of Georgia.

Section I – Health History (continued)

| | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test) or urine test, x-ray(s), CAT scan, MRI, or mammogram? | <input type="checkbox"/> | <input type="checkbox"/> | 7. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following? | | |
| 2. Have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition? | <input type="checkbox"/> | <input type="checkbox"/> | A. Abnormal Pap smear | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Step 2) | <input type="checkbox"/> | <input type="checkbox"/> | B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you pregnant or an expectant father, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months? | <input type="checkbox"/> | <input type="checkbox"/> | C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have implants, prosthesis or retained hardware? | | | D. Male infertility | <input type="checkbox"/> | <input type="checkbox"/> |
| A. Breast implants | <input type="checkbox"/> | <input type="checkbox"/> | E. Female fertility/infertility | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Eye/limb prosthesis | <input type="checkbox"/> | <input type="checkbox"/> | F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart, circulatory or blood disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump | <input type="checkbox"/> | <input type="checkbox"/> | G. Kidney, bladder or prostate disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Joint replacement/internal fixations (i.e. pins, plates, rods etc.), neurostimulators | <input type="checkbox"/> | <input type="checkbox"/> | H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Any other prosthesis or implant (other than dental) | <input type="checkbox"/> | <input type="checkbox"/> | I. Hernia; hemorrhoid; rectal, or intestinal disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following? (all answers must be checked yes or no) | | | J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| A. Headaches requiring prescription medication | <input type="checkbox"/> | <input type="checkbox"/> | K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Loss of consciousness | <input type="checkbox"/> | <input type="checkbox"/> | L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Sleep apnea/breathing difficulties while sleeping | <input type="checkbox"/> | <input type="checkbox"/> | M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Recurrent fainting, weakness or dizziness | <input type="checkbox"/> | <input type="checkbox"/> | N. Psoriasis, rosacea, acne or skin disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Paralysis or numbness/tingling in limbs | <input type="checkbox"/> | <input type="checkbox"/> | O. Cataract, glaucoma, eye or ear disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | P. Diabetes, thyroid, endocrine glands | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Increased/irregular heart beat | <input type="checkbox"/> | <input type="checkbox"/> | 8. Within the last 5 years, have you experienced, suffered from, consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Low or high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 9. Within the last 5 years, have you been advised by a health care professional to reduce alcohol intake? | <input type="checkbox"/> | <input type="checkbox"/> |
| I. High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | 11. Within the last 5 years have you had counseling or treatment for any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in Step 2.) | | |
| K. Heartburn (recurrent) | <input type="checkbox"/> | <input type="checkbox"/> | A. Obsessive Compulsive Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Abnormal and/or Recurrent bleeding (unrelated to menstruation) | <input type="checkbox"/> | <input type="checkbox"/> | B. Minor depression | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Recurrent diarrhea and/or recurrent vomiting | <input type="checkbox"/> | <input type="checkbox"/> | C. Anxiety/panic attacks | <input type="checkbox"/> | <input type="checkbox"/> |
| N. Unexplained weight loss | <input type="checkbox"/> | <input type="checkbox"/> | D. Attention Deficit Disorder (ADD/ADHD) | <input type="checkbox"/> | <input type="checkbox"/> |
| O. Blood, sugar, and/or protein in urine | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| P. Recurrent pain (including back pain) | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Q. Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| R. Mass, cyst(s), or lump(s) in any body part including breast | <input type="checkbox"/> | <input type="checkbox"/> | | | |

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Section I – Health History (continued)

| | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 12. Within the last 5 years, have you experienced (suffered from) or consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to drug abuse? | <input type="checkbox"/> | <input type="checkbox"/> | B. Ankylosing Spondylitis, Alzheimer’s Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Diabetes, Emphysema, Gaucher’s Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson’s Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma. | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. In the past 10 years have you had consultation, been diagnosed, had treatment or treatment recommended for any of the following: | | | 17. Are you a candidate for, or have you ever received an organ or bone marrow transplant? | <input type="checkbox"/> | <input type="checkbox"/> |
| A. Schizophrenia, Major Depression/ BiPolar Disorder | <input type="checkbox"/> | <input type="checkbox"/> | 18a. Within the last 5 years, have you had any illness, physical injury, persisting or new physical symptoms and/or health problems not mentioned elsewhere on this application that have not been evaluated or that you plan to have evaluated by a licensed health practitioner? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Eating disorder (i.e. anorexia/bulimia) | <input type="checkbox"/> | <input type="checkbox"/> | 18b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Down’s Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Autism | <input type="checkbox"/> | <input type="checkbox"/> | 20. Date last seen by a physician: _____ | | |
| E. Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> | Reason: _____ | | |
| 14. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 15. Have you ever been diagnosed with hepatitis? (check all types that apply) | | | | | |
| A. Hepatitis A | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| B. Hepatitis B | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| C. Hepatitis C, D, E | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 16. Have you ever been diagnosed with, or treated for any of the following? | | | | | |
| A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Other Health Questions

| | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1a. Within the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco? (If cigarettes, please check the appropriate box below based on the number of cigarettes smoked per day during the last 12 months.) | <input type="checkbox"/> | <input type="checkbox"/> | 2. Within the past 12 months, have you consumed alcoholic beverages? (If yes, please check the appropriate box below based on your average weekly consumption of alcoholic beverages during the last 12 months. One beverage equals 12 oz. of beer, 4 oz. of wine, or 1 oz. of liquor.) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-39 | | | <input type="checkbox"/> 0-7 <input type="checkbox"/> 8-14 <input type="checkbox"/> 15-20 | | |
| <input type="checkbox"/> 40-49 <input type="checkbox"/> 50 or more | | | <input type="checkbox"/> 21-26 <input type="checkbox"/> 27-35 <input type="checkbox"/> 36 or more | | |
| 1b. Within the past 12 months, have you stopped using all tobacco products? If yes, how many months ago has it been since you stopped? | <input type="checkbox"/> | <input type="checkbox"/> | 3. Within the past 12 months, have you used marijuana? (If yes, please check the appropriate box below.) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 1-3 months | | | <input type="checkbox"/> less than 4 times per month | | |
| <input type="checkbox"/> 4-6 months | | | <input type="checkbox"/> 5 - 7 times per month | | |
| <input type="checkbox"/> 7-9 months | | | <input type="checkbox"/> 8 or more times per month | | |
| <input type="checkbox"/> 10-12 months | | | 4. Within the past 5 years, have you used cocaine, heroin, ecstasy, LSD or any other illicit drug(s)? | <input type="checkbox"/> | <input type="checkbox"/> |

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Section I – Health History *(continued)*

STEP 2: If you answered “YES” to any of the health history questions, give complete details (see the example below)

| Question Number of “YES” | Patient First Name | Physician Name & Telephone (with area code) | Specific Diagnosis & Treatment | Name & Dosage of Medication & Dates of Use | | Duration of Condition | | Was Surgery Performed? | | Description of Surgery/ Procedures & Date(s) (mm/yyyy) | Current Status |
|--------------------------|--------------------|---|--------------------------------|---|---------------|-----------------------|---------------|-------------------------------------|--------------------------|--|----------------|
| | | | | Begin (mm/yyyy) | End (mm/yyyy) | Begin (mm/yyyy) | End (mm/yyyy) | YES | NO | | |
| Example: #17 | Mary | Dr. John Doe 555-555-1000 | Tonsillitis | Amoxicillin 250 mg. 4x day 08/2002 09/2002 | | 08/2002 | 09/2002 | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Tonsillectomy 09/2002 | Good |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | |

Please check box if an additional sheet(s) of paper has been completed for this chart.

Note: Please make a copy of the signed application for your records prior to submitting to Blue Cross Blue Shield of Georgia.

Section I – Health History *(continued)*

Prescription Medications

List *all* medications taken within the last 12 months by any family member listed on this application (if not indicated in Step 2)

| Family Member | Medication/Dosage/Frequency | Illness for which Medication is Prescribed | Date Prescribed (mm/dd/yyyy) | Date Discontinued (mm/dd/yyyy) | Name, Phone No. of Physician or Hospital |
|------------------|-----------------------------|--|------------------------------|--------------------------------|---|
| Example: Mary | Lopressor/100mg/daily | Tonsillitis | 08/01/2002 | 09/09/2003 | Name: <u>Dr. John Doe</u> Phone: <u>555-555-1000</u> |
| | | | | | Name: _____ Phone: _____ |
| | | | | | Name: _____ Phone: _____ |
| | | | | | Name: _____ Phone: _____ |
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| | | | | | Name: _____ Phone: _____ |
| | | | | | Name: _____ Phone: _____ |

Please check box if an additional sheet(s) of paper has been completed for this chart.

Note: Please make a copy of the signed application for your records prior to submitting to Blue Cross Blue Shield of Georgia.

Section J – Billing Options

INITIAL PREMIUM

- Check Enclosed (If paying by check, make the check payable to Blue Cross Blue Shield of Georgia.)
- Credit Card (see below)

Total amount enclosed/charged: \$

METHOD (select one)

- BILL TO HOME**—Bills will be sent to your home billing address unless a separate billing address is listed below.
- BILL TO OTHER**

| Name | Address (street and P.O. Box if applicable) | City | State | Zip |
|------|---|------|-------|-----|
| | | | | |

- AUTOMATIC BANK DRAFT** (automatic premium withdrawals to begin second month)—your premium will be deducted on, or about the 5th of each month. (You may attach a **blank** voided check or complete the information below.)

I authorize Blue Cross Blue Shield of Georgia to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. I understand that this authorization is in effect until I notify Blue Cross Blue Shield of Georgia that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Blue Cross Blue Shield of Georgia and my financial institution have the right to discontinue the withdrawals if they wish to do so.

| | |
|------------------------------------|--|
| Account Holder Name (please print) | Account Holder Signature (if other than the applicant) X |
| Name of Bank | Account Number |
| Routing Number | Account Holder's SSN |

- IF PAYING BY CREDIT CARD:** A credit card can be used for the initial premium payment only.

Credit card information

| | |
|--|---------------------|
| Cardholder Name (as shown on the credit card): | Cardholder Address: |
|--|---------------------|

If applicant is using the credit card of another cardholder: By signing this form, applicant represents and warrants that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for this payment and any charges accruing to it.

| | |
|---|--|
| Type of credit card: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover | Credit Card Number: Expiration Date (month/year): |
|---|--|

Authorization:

*I authorize Blue Cross Blue Shield of Georgia to charge the credit card indicated for the amount specified in **Initial Premium**.*

| |
|----------------------------------|
| Applicant signature: X |
|----------------------------------|

Note: Please make a copy of the signed application for your records prior to submitting to Blue Cross Blue Shield of Georgia.

Section K – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

1. **I understand that it is mandatory that I notify Blue Cross Blue Shield of Georgia (BCBSGa), in writing, immediately if I (the applicant) or any other person for whom coverage is sought received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date. I understand that in this situation the new information will not be considered as a pre-existing condition. However, Blue Cross Blue Shield of Georgia has the right to review my application using the new information to determine whether to approve the application for coverage and, if approved, to determine the appropriate premium rate.**
2. I understand that sending my initial premium with this application, and the receipt of my payment by Blue Cross Blue Shield of Georgia, does not mean that coverage has been approved. I may not assign any payment under my Blue Cross Blue Shield of Georgia program. I am applying for the coverage selected on this application. I understand that any premium quote provided is preliminary and review of my application by medical underwriting may change the premium or result in a denial of coverage. I understand that, to the extent permitted by law, Blue Cross Blue Shield of Georgia reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that if my application is denied, my bank account or credit card will not be charged.
3. **I understand that preexisting conditions are limited to 12 months after enrollment for conditions in existence within 12 months immediately prior to my enrollment for which medical advice, diagnosis, care or treatment was recommended or received. Pregnancy is considered a preexisting condition.**
4. I am responsible to timely notify Blue Cross Blue Shield of Georgia of any change that would make me or any dependent ineligible for coverage.
5. I understand Blue Cross Blue Shield of Georgia may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Blue Cross Blue Shield of Georgia automatic debit process and will only occur each time I send a check to Blue Cross Blue Shield of Georgia. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
6. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Blue Cross Blue Shield of Georgia and myself.
7. I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
8. I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 6 months or more; he or she is mentally competent; he or she is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
9. By signing this application I certify that I understand that I alone am responsible for reading and accurately completing this application, and I must communicate any changes to my status. If I have selected term life coverage, I understand that I am providing the information on this application to the underwriting department of Greater Georgia Life Insurance Company (GGL).
10. I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Blue Cross Blue Shield of Georgia in accepting this application. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

Note: Please make a copy of the signed application for your records prior to submitting to Blue Cross Blue Shield of Georgia.



Authorization for Use of Protected Health Information

By signing below, I authorize Blue Cross Blue Shield of Georgia (BCBSGa) to obtain any necessary medical records from any physicians, hospitals and/or any other health care providers concerning my care and the care of any family member listed on my Application. I understand this information will be used to determine whether my listed family members and I are eligible for enrollment in the coverage requested.

I understand that BCBSGa will not process my Application for enrollment unless this Authorization is signed and returned with my Application. This Authorization permits BCBSGa to request from health care providers any additional medical information needed to determine my eligibility for coverage and/or the eligibility of any family members listed on my Application. This Authorization will expire within one (1) year from the date indicated below.

I understand that I may revoke this Authorization at any time during the Application process by submitting a completed Authorization Revocation Form to BCBSGa. I may request an Authorization Revocation Form by contacting BCBSGa or the Broker / Agent assisting with my enrollment. If I revoke this Authorization, I understand that I / we will not be considered by BCBSGa for enrollment in a health plan.

IF LISTED ON YOUR APPLICATION, YOUR SPOUSE/DOMESTIC PARTNER AND EACH DEPENDENT CHILD OVER AGE 18 MUST SIGN BELOW.

| | | | | |
|-----------|--|---|----------------------|--------------------|
| SIGN HERE | Printed name of Applicant | Signature of Applicant* or Legal Representative X | Date of Birth / / | Date Signed / / |
| | Printed name of Spouse or Domestic Partner | Signature of Spouse or Domestic Partner or Legal Representative X | Date of Birth / / | Date Signed / / |
| | Printed name of Dependent Child over 18 | Signature of Dependent Child over 18 X | Date of Birth / / | Date Signed / / |
| | Printed name of Dependent Child over 18 | Signature of Dependent Child over 18 X | Date of Birth / / | Date Signed / / |

**(or Custodial Parent's or Guardian's signature if applicant is under age 18)*

| Designated Legal Representative/Guardian | |
|--|----------------------------------|
| If this form is signed by a legal representative/guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the ability of the legal representative to act on the individual's behalf, must be attached. | |
| Legal Representative (please print full name) | Legal Relationship to Individual |
| Signature X | Date |

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Conditional Receipt

THIS RECEIPT DOES NOT PROVIDE ANY COVERAGE UNTIL ALL THE TERMS AND CONDITIONS LISTED BELOW ARE MET.

Blue Cross Blue Shield of Georgia (BCBSGa) has received from the named Applicant an advance deposit equal to the first month's dues together with an application for designated health insurance coverage. Such payment is accepted subject to the following conditions:

Subject to the provisions of the contract, the coverage applied for will be effective from, and the contract date as of, the day following acceptance by Medical Underwriting, unless otherwise specifically stated, provided that the payment evidenced by this receipt is the full first month's dues and provided that BCBSGa determines that as of the date of the application all proposed covered persons were acceptable for coverage and for the benefits applied for. If the application is not approved by BCBSGa said Plan shall incur no liability and the payment evidenced by this receipt will be refunded to the applicant. No one has the authority to waiver or modify any of the terms or conditions of this receipt.

If you do not receive a contract within 60 days, please contact Blue Cross Blue Shield of Georgia Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

Abbreviated Notice Of Insurance Information Practices

PRIVACY ACT. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. We need your answers to decide if you qualify for coverage. We are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals.

ALL DATA CONFIDENTIAL. Official Code of Georgia, code section 33-39-5, subsection (c) (1 through 4) requires that:

1. Personal information may be collected from persons other than the individual or individuals proposed for coverage;
2. Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization;
3. A right of access and correction exists with respect to all personal information collected;
4. The notice prescribed in subsection (b) of the above referenced Code section will be furnished to the applicant or policyholder upon request.

ACCESS TO YOUR DATA. You have the right to see or obtain a photocopy of your personal information which we have. You also have the right to send us a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of our information practices, please contact Blue Cross Blue Shield of Georgia Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

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