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): ☐ New Coverage ☐ Change BCBSGA Individual policy coverage - Policy No. _____
☐ Add dependent(s) to current coverage - Policy No. _____

Effective date requested: If your application is approved, your coverage can start on any day of the month after the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.

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

Marital Status	Height (Ft./In.)	Weight	Sex	Age	Date of Birth
☐ Single ☐ Married ☐ Domestic Partner	/		M F		/ /

Daytime Phone Number	Evening Phone Number	E-mail Address*:
( )	( )	If possible, do you want E-mail notification? ☐ Yes ☐ No

Are you a legal resident of the United States and a resident of the state of Georgia?	Language Choice (Optional)
☐ Yes ☐ No	☐ English ☐ Spanish ☐ Korean ☐ Chinese (C/M)

Are all applicants listed on this application United States citizens? ☐ Yes ☐ No

If NO, who? _____ and how many months/years have they resided in the United States? _____ years and _____ months

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Social Security Number*

Relationship	Height (Ft./In.)	Weight	Sex	Age	Date of Birth
☐ Spouse ☐ Domestic Partner	/		M F		/ /

Are you a legal resident of the United States and a resident of the state of Georgia?	Language Choice (Optional)
☐ Yes ☐ No	☐ English ☐ Spanish ☐ Korean ☐ Chinese (C/M)

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

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn 26). (List all dependents beginning with the eldest.)

First, MI (last name if different)	Social Security Number*	Sex	Age	Date of Birth mm/dd/yyyy	Height Ft. / In.	Weight Lbs.
		M F		/ /	/	
		M F		/ /	/	
		M F		/ /	/	
		M F		/ /	/	
		M F		/ /	/	

*This information is used for internal purposes only.

Section E – Medical Coverage (Select plan, deductible, and optional riders below.)

BCBSGA will enroll all eligible family members unless otherwise instructed below.

☐ I, the Applicant, request that BCBSGA not enroll any eligible applicants unless ALL family members qualify.

☐ **Premier Plus POS**	☐ $750 EK	☐ $1,500 EL	☐ $2,500 EM	☐ $3,500 EN	☐ $5,000 EO	☐ $7,500 EP
	☐ $10,000 EQ	☐ $20,000 ER				
	☐ Consumer Choice Option		☐ Maternity Rider*			
☐ **Premier Plus PPO**	☐ $750 FI	☐ $1,500 FJ	☐ $2,500 FL	☐ $3,500 FM	☐ $5,000 FN	☐ $7,500 FO
	☐ $10,000 FP	☐ $20,000 FQ				
	☐ Consumer Choice Option		☐ Maternity Rider*			
☐ **SmartSense Plus POS**	☐ $750 FA	☐ $1,500 FB	☐ $2,500 FC	☐ $3,500 FD	☐ $5,000 FE	☐ $7,500 FF
	☐ $10,000 FG	☐ $20,000 FH				
	☐ Consumer Choice Option		☐ Enhanced Drug Rider			
☐ **SmartSense Plus PPO**	☐ $750 ES	☐ $1,500 ET	☐ $2,500 EU	☐ $3,500 EV	☐ $5,000 EW	☐ $7,500 EX
	☐ $10,000 EY	☐ $20,000 EZ				
	☐ Consumer Choice Option		☐ Enhanced Drug Rider			

HSA Compatible Plans

☐ Single ForwardFocus HSA POS (80%coinsurance)	☐ $1,750 DI	☐ $2,500 DJ	☐ Consumer Choice Option	☐ Maternity Rider*
☐ Single ForwardFocus HSA POS (100%coinsurance)	☐ $3,500 DK	☐ $5,500 DL	☐ Consumer Choice Option	☐ Maternity Rider*
☐ Family ForwardFocus HSA POS (80%coinsurance)	☐ $3,500 DM	☐ $5,000 DN	☐ Consumer Choice Option	☐ Maternity Rider*
☐ Family ForwardFocus HSA POS (100%coinsurance)	☐ $7,000 DO	☐ $11,000 DP	☐ Consumer Choice Option	☐ Maternity Rider*
☐ Single ForwardFocus HSA PPO (80%coinsurance)	☐ $1,750 DQ	☐ $2,500 DR	☐ Consumer Choice Option	☐ Maternity Rider*
☐ Single ForwardFocus HSA PPO (100%coinsurance)	☐ $3,500 DS	☐ $5,500 DT	☐ Consumer Choice Option	☐ Maternity Rider*
☐ Family ForwardFocus HSA PPO (80%coinsurance)	☐ $3,500 DU	☐ $5,000 DV	☐ Consumer Choice Option	☐ Maternity Rider*
☐ Family ForwardFocus HSA PPO (100%coinsurance)	☐ $7,000 DW	☐ $11,000 DX	☐ Consumer Choice Option	☐ Maternity Rider*

☐ Yes, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Blue Cross and Blue Shield of Georgia (BCBSGA) will provide your information to BCBSGA's banking partner. (Please fill in your social security number in section B.)

☐ No, I DO NOT want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above.

Maternity Rider available on deductibles of $2,500 & higher

Section F – Dental Coverage Selection (optional coverage at an additional cost per individual)

☐ **BlueChoice® Dental** GAD1

☐ Yes, I wish to add dental coverage. If Yes, select ONE coverage type (applies to individuals listed on this application only):

- ☐ Applicant only
- ☐ Applicant, Spouse and all dependent children listed
- ☐ Applicant & all dependent children listed

☐ Yes, if myself or any listed family member are declined for medical coverage, still enroll **all members selected above, if eligible.**

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

Section G – Greater Georgia Life Insurance Company Term Life Insurance (optional coverage at an additional cost per individual)

☐ Yes, in addition to my medical coverage, I wish to apply for Term Life Insurance. GAL1

Do you, the applicant, own an existing life policy? ☐ Yes ☐ No

If you answered "Yes" to the above question, inform the agent with whom you are working (if any), who will provide you an "Important Notice: Replacement of Life Insurance," which you must read and complete.

By applying for this proposed life policy, do you intend to replace, discontinue or change any existing life policy? ☐ Yes ☐ No

Provide information below. Applicants must meet Blue Cross and Blue Shield of Georgia's Underwriting Guidelines to qualify for Term Life Insurance Coverage. Applicants under the age of one year are not eligible for Life Insurance. All Term Life policies terminate at age 65.

Applicants	Birthday (mm/dd/yyyy)	Coverage Amount (select one)	Beneficiary**	% Allocation	Relationship	Social Security Number
	/ /	☐ $15,000 ☐ $75,000* ☐ $25,000 ☐ $100,000* ☐ $50,000*	Primary:			
			Contingent:			
	/ /	☐ $15,000 ☐ $75,000* ☐ $25,000 ☐ $100,000* ☐ $50,000*	Primary:			
			Contingent:			
	/ /	☐ $15,000 ☐ $75,000* ☐ $25,000 ☐ $100,000* ☐ $50,000*	Primary:			
			Contingent:			
	/ /	☐ $15,000 ☐ $75,000* ☐ $25,000 ☐ $100,000* ☐ $50,000*	Primary:			
			Contingent:			

* Amounts above $25,000 are not available to applicants under the age of 20. If selected by an approved applicant under age 20, the selection will default to $25,000.

** **If a beneficiary is not listed** and a policy is issued, death benefits will be paid in accordance with the Beneficiary Provision of the Policy.

Section H – Other Health Coverage

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

If yes, give name. _____

Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation? ☐ Yes ☐ No

If yes, give name and reason: _____

_____ Start date of coverage: ____/____/_____ End date of coverage: ____/____/_____

Do you, or anyone applying for coverage, currently have health care coverage? ☐ Yes ☐ No

Did you or your eligible dependents have creditable coverage within the past 63 days? (You may be eligible for preexisting credit. Preexisting condition limitations do not apply to applicants under the age of nineteen (19).) ☐ Yes ☐ No

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 ☐ Group ☐ Individual	Effective Date of Coverage	Cancellation Date of Coverage

Will you be canceling this coverage if approved for Blue Cross and 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 ☐ Group ☐ Individual	Effective Date of Coverage	Cancellation Date of Coverage

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

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Section I – Health History - For Each Family Member (IMPORTANT: This section has two steps)

STEP 1 - ***All questions must be answered or the application will be returned.***

GIVE COMPLETE DETAILS IN STEP 2 FOR ALL SELECTED CHECK BOXES OTHER THAN THE "NO TO ALL" CHECK BOXES FOR QUESTIONS 1 - 14 BELOW.

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

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 then discover an act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact, 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 and Blue Shield of Georgia, you must fully disclose and answer all health history questions.

PLEASE NOTE: The health history questions apply to ANY medical advice, diagnosis, care or treatment that you received or that a healthcare provider recommended that you receive for any of the conditions listed.

1. Bone, Joint and Muscle Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Arthritis (osteo-, rheumatoid or other)
- ☐ B. Back, neck, muscle, disc or tendon problems
- ☐ C. Bursitis
- ☐ D. Gout
- ☐ E. Fibromyalgia
- ☐ F. Osteopenia
- ☐ G. Ankylosing Spondylitis
- ☐ H. Osteoporosis
- ☐ I. TMJ (Temporomandibular Joint) disorder
- ☐ J. Other bone, joint or muscle problems
- ☐ K. **NO to all bone, joint and muscle problems**

2. Brain and Nerve Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Headaches requiring prescription medication
- ☐ B. Migraines
- ☐ C. MS (Multiple Sclerosis)
- ☐ D. Alzheimer's Disease or Dementia
- ☐ E. Muscular Dystrophy
- ☐ F. Parkinson's Disease
- ☐ G. Paralysis
- ☐ H. Seizures or convulsions
- ☐ I. Head Injury
- ☐ J. Stroke or Transient Ischemic Attack (TIA)
- ☐ K. Other brain or nerve problem
- ☐ L. **NO to all brain and nerve problems**

3. Breathing or Lung Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Asthma
- ☐ B. Bronchitis
- ☐ C. COPD (Chronic Obstructive Pulmonary Disorder)
- ☐ D. Cystic fibrosis
- ☐ E. Emphysema
- ☐ F. Pneumonia
- ☐ G. Sleep apnea
- ☐ H. Tuberculosis
- ☐ I. Other breathing or lung problems
- ☐ J. **NO to all breathing or lung problems**

4. Cancer, Cyst or Tumor

Within the last TEN years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Cancer
- ☐ B. Basal cell
- ☐ C. Squamous cell
- ☐ D. Melanoma
- ☐ E. Polyp or Papilloma
- ☐ F. Cyst, growth, lump, mass or tumor
- ☐ G. Other cancer, cyst or tumor disorder
- ☐ H. **NO to all cancer, cyst or tumors**

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Section I – Health History - For Each Family Member (IMPORTANT: This section has two steps) (continued)

5. Congenital (birth) or Developmental Disorders

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Autism
- ☐ B. Cerebral Palsy
- ☐ C. Cleft palate and/or lip
- ☐ D. Mental retardation
- ☐ E. Other congenital or developmental disorders
- ☐ F. **NO to all congenital or developmental disorders**

6. Eyes, Ears, Nose and Throat Disorders

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Allergies including hay fever and rhinitis
- ☐ B. Cataracts
- ☐ C. Detached retina
- ☐ D. Deviated nasal septum or polyps
- ☐ E. Ear infections (more than 2 in the last 12 months)
- ☐ F. Sinus infections (more than 2 in the last 12 months)
- ☐ G. Eye infections other than pink eye
- ☐ H. Glaucoma
- ☐ I. Hearing loss or cochlear implants
- ☐ J. Problems with tonsils or adenoids
- ☐ K. Other eyes, ears, nose or throat problems
- ☐ L. **NO to all eyes, ears, nose and throat problems**

7. Kidney or Bladder Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Bladder infections
- ☐ B. Pyelonephritis or Kidney infection
- ☐ C. Kidney failure
- ☐ D. Dialysis
- ☐ E. Kidney stones
- ☐ F. Urinary tract infections or problems
- ☐ G. Other kidney or bladder problems
- ☐ H. **NO to all kidney or bladder problems**

8. Nervous, Mental, Emotional or Behavioral Health Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Alcohol abuse
- ☐ B. Drug abuse
- ☐ C. Attention Deficit Disorder (ADD/ADHD)
- ☐ D. Bipolar Disorder
- ☐ E. Obsessive Compulsive Disorder
- ☐ F. Depression
- ☐ G. Anxiety
- ☐ H. Eating Disorder
- ☐ I. Panic Disorder
- ☐ J. Schizophrenia
- ☐ K. Other mental health problems
- ☐ L. **NO to all nervous, mental, emotional or behavioral health problems**

9. Male or Female Reproductive Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Cyst on ovary or problems with ovaries
- ☐ B. Uterine fibroids
- ☐ C. Endometriosis or Pelvic Inflammatory Disease
- ☐ D. Infertility (problems getting pregnant or in vitro fertilization)
- ☐ E. Abnormal pap smear or mammogram
- ☐ F. Sexually transmitted disease such as HPV (Human Papilloma Virus)
- ☐ G. Herpes or genital or anal warts
- ☐ H. Impotence or erectile dysfunction
- ☐ I. Disorders of the testicle
- ☐ J. Prostate problems
- ☐ K. Other female or male reproductive problems
- ☐ L. **NO to all male or female reproductive problems**

10. Heart, Blood and Blood Vessel Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Anemia
- ☐ B. Sickle cell anemia
- ☐ C. Hemophilia
- ☐ D. Leukemia
- ☐ E. Heart murmur or irregular heartbeat
- ☐ F. Aneurysm
- ☐ G. Angina (Chest Pain)
- ☐ H. Blood clots or phlebitis
- ☐ I. Heart disease or heart attack
- ☐ J. Heart valve disease or disorder
- ☐ K. High blood pressure (Hypertension)
- ☐ L. High cholesterol or triglycerides
- ☐ M. Raynaud's disease
- ☐ N. Varicose veins
- ☐ O. Pacemaker
- ☐ P. Other heart, blood or blood vessel problems
- ☐ Q. **NO to all heart, blood and blood vessel problems**

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Section I – Health History - For Each Family Member (IMPORTANT: This section has two steps) (continued)

11. Metabolic, Immune System and Endocrine Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. HIV, AIDS or AIDS related complex
- ☐ B. Diabetes or high blood sugar
- ☐ C. Hormone or growth hormone disorders
- ☐ D. Lupus or SLE (Systemic Lupus)
- ☐ E. Thyroid or adrenal disorders
- ☐ F. Scleroderma
- ☐ G. Gaucher's disease
- ☐ H. Other metabolic, immune system and endocrine problems
- ☐ I. **NO to all metabolic, immune system and endocrine problems**

12. Skin Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Acne
- ☐ B. Psoriasis
- ☐ C. Rosacea
- ☐ D. Eczema or dermatitis
- ☐ E. Fungal infections
- ☐ F. Recurring or unresolved skin lesions (sores)
- ☐ G. Keratosis
- ☐ H. Severe burns
- ☐ I. Shingles
- ☐ J. Other skin disorders
- ☐ K. **NO to all skin problems**

13. Stomach, Intestinal and Liver Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Colitis
- ☐ B. Chronic diarrhea
- ☐ C. Irritable bowel syndrome (IBS)
- ☐ D. Colon polyps
- ☐ E. Crohn's disease
- ☐ F. Gallstones or gallbladder disorder
- ☐ G. Diverticulitis or diverticulosis
- ☐ H. GERD (Gastroesophageal Reflux, or Acid Reflux)
- ☐ I. Hemorrhoids
- ☐ J. Hepatitis A
- ☐ K. Hepatitis B
- ☐ L. Hepatitis C, D, or E
- ☐ M. Hepatitis – type unknown
- ☐ N. Hernia
- ☐ O. Jaundice
- ☐ P. Liver disease/cirrhosis
- ☐ Q. Pancreatitis
- ☐ R. Ulcers
- ☐ S. Obesity surgery
- ☐ T. Constipation
- ☐ U. Other stomach, intestinal or liver problems
- ☐ V. **NO to all stomach, intestinal and liver problems**

14. Unexplained Problems or Symptoms in the last year

Within the last 12 MONTHS, has any applicant had any of the following signs or symptoms for which you have not seen a doctor or other healthcare provider:

- ☐ A. Chest pain
- ☐ B. Dizziness
- ☐ C. Loss of consciousness/blackouts
- ☐ D. Pain in back, abdomen (stomach) or pelvis
- ☐ E. Numbness or tingling in the limbs
- ☐ F. Abnormal or recurrent bleeding (not related to menstruation)
- ☐ G. Shortness of breath or trouble breathing
- ☐ H. Lump or unexplained growth
- ☐ I. Tiredness that does not go away
- ☐ J. Weight loss of more than 10 pounds for reasons other than a weight loss program
- ☐ K. **NO to all unexplained problems or symptoms**

STEP 1 (continued) ***- All questions must be answered or the application will be returned.***

GIVE COMPLETE DETAILS IN STEP 2 FOR ANY LIFESTYLE OR OTHER QUESTIONS 15 - 24 ANSWERED "YES."

Lifestyle Questions

Tobacco Use		**YES**	**NO**
15. a) Within the last **12 MONTHS**, has any applicant used tobacco products or smoking cessation products?	Applicant	☐	☐
	Spouse or Domestic Partner	☐	☐
b) If cigarettes, have you smoked 40 or more per day?	Applicant	☐	☐
	Spouse or Domestic Partner	☐	☐
Alcohol and Drugs			
16. Within the last **TEN** years, has any applicant used illegal drugs or been advised by a doctor or other healthcare provider to discontinue or decrease alcohol or drug use?		☐	☐

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Section I – Health History - For Each Family Member (IMPORTANT: This section has two steps) (continued)

STEP 1 (continued) ***- All questions must be answered or the application will be returned.***

GIVE COMPLETE DETAILS IN STEP 2 FOR ANY LIFESTYLE OR OTHER QUESTIONS 15 - 24 ANSWERED "YES."

Other Questions

		YES	NO
17.	Within the last **TEN** years, has any applicant received an organ or bone marrow transplant?	☐	☐
18.	Is any applicant currently pregnant (includes positive pregnancy test), an expectant parent, or in the process of adoption or surrogate pregnancy?	☐	☐
19.	Within the last **FIVE** years, has any applicant had breast or other implants, internal fixation (pins, rods, screws, plates), joint replacement, prosthetic device, monitoring device, defibrillator, pacemaker, heart valve replacement, shunt, stent, or neuro stimulator?	☐	☐
20.	Within the last **12 MONTHS**, has any applicant been evaluated or treated in an emergency room or urgent care for any condition ***other than*** flu, sinus infection, pregnancy, bladder infection, hives, or for a sprain/strain that resolved in less than one month?	☐	☐
21.	Within the last **FIVE** years, has any applicant had treatment or surgery in a hospital or outpatient facility ***other than***: childbirth, fracture of a single bone in the hand, foot, arm or lower leg, hernia repair, hysterectomy, insertion of ear tubes in a child, tonsillectomy, tubal ligation, vasectomy, removal of appendix, or removal of gall bladder and was the procedure more than 3 months ago with no current treatment?	☐	☐
22.	Within the last **TEN** years, has any applicant been advised by a healthcare provider to have testing, examination, evaluation, treatment, therapy, or surgery that has not yet been completed?	☐	☐
23.	Within the last **12 MONTHS**, has any applicant received a prescription or taken any prescribed medication ***other than*** birth control for contraception, thyroid medication, or short term (10 days or less) antibiotics?	☐	☐
24.	Within the last **THREE** years, has any applicant been convicted of DUI two or more times?	☐	☐

STEP 2 - Prescription Medications

List ***ALL*** medications taken within the last 12 MONTHS by any applicant listed on this application. Use an additional sheet of paper if necessary. All additional pages must be signed and dated by the primary applicant.

Applicant Name	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	Amoxicillin 250 mg 4x day	Tonsillitis	08/01/2008	09/01/2008	**Name:** Dr. John Doe **Phone:** 555-555-1000
					Name: **Phone:**
					Name: **Phone:**
					Name: **Phone:**
					Name: **Phone:**
					Name: **Phone:**
					Name: **Phone:**

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

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Section I – Health History - For Each Family Member (IMPORTANT: This section has two steps) (continued)

STEP 2 (continued) - Health History

Give complete details below for all selected check boxes other than the "NO to all" check boxes for questions 1-14 and all Lifestyle or Other questions answered "YES" (see example below). Not providing complete details will delay the application process. Use an additional sheet of paper if necessary. All additional pages must be signed and dated by the primary applicant.

Question Number	Patient First Name	Name of Hospital, Clinic and/or Person Providing Care	Specific Diagnosis & Treatment	Name & Dosage of Medication & Dates of Use		Duration of Condition		Was Surgery Performed?		Description of Surgery/ Procedures & Date(s) (mm/yyyy)	Still Under Treatment
				Begin (mm/yyyy)	End (mm/yyyy)	Begin (mm/yyyy)	End (mm/yyyy)	YES	NO		
Example: #6	Mary	Dr. John Doe	Tonsillitis	Amoxicillin 250 mg 4x day 08/2008	09/2008	08/2008	09/2008	☑	☐	Tonsillectomy 09/2008	☐
								☐	☐		☐
								☐	☐		☐
								☐	☐		☐
								☐	☐		☐
								☐	☐		☐
								☐	☐		☐
								☐	☐		☐
								☐	☐		☐
								☐	☐		☐

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

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Section J – Billing Options

INITIAL PREMIUM (required)

☐ Check Enclosed (If paying by check, make the check payable to Blue Cross and 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 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 and 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 and Blue Shield of Georgia that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Blue Cross and Blue Shield of Georgia and my financial institution have the right to discontinue the withdrawals if they wish to do so. I understand that a service charge will be incurred for any withdrawal not honored.

Account Holder Name (please print)		Account Holder's SSN
Account Holder Signature (if other than the applicant) **X**		Date (mm/dd/yyyy)
Name of Bank	Routing Number	Account Number

☐ **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: ☐ VISA ☐ MasterCard ☐ Discover	Credit Card Number:	Expiration Date (month/year):

Authorization:

I authorize Blue Cross and Blue Shield of Georgia to charge my VISA, MasterCard, or Discover credit card for the initial premium payment. If the results of the health underwriting for my policy result in a different premium than my original premium quote, I also authorize Blue Cross and Blue Shield of Georgia to charge my VISA, MasterCard, or Discover credit card for this difference if necessary.

I agree that Blue Cross and Blue Shield of Georgia is fully protected in honoring any credit card payments. I further agree that if any credit card payment is dishonored, with or without cause, intentionally or inadvertently, Blue Cross and Blue Shield of Georgia is under no liability whatsoever, including any fees imposed by my bank, if my credit card is rejected even though such dishonor results in termination of coverage.

Applicant signature: **X**

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

Please read this section carefully before signing the application.

1. **CURRENT HEALTH COVERAGE:** If you currently have health coverage, we strongly recommend that you maintain your current coverage and request an effective date of 75 days from the date of application. This will help ensure that your application is processed before you surrender your present insurance.
2. **I understand that it is mandatory that I notify Blue Cross and 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 the coverage effective date or the date underwriting approves, whichever is later. I understand that in this situation, BCBSGA has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be delayed or reformed or, for applicants age nineteen (19) and older, benefits denied due to the illness, injury or condition being treated as a preexisting condition.**
3. I understand that sending my initial premium with this application, and the receipt of my payment by Blue Cross and Blue Shield of Georgia, does not mean that coverage has been approved. I may not assign any payment under my Blue Cross and 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 and 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.
4. **For applicants age nineteen (19) and older, 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.**
5. I am responsible to timely notify Blue Cross and Blue Shield of Georgia of any change that would make me or any dependent ineligible for coverage.
6. I understand Blue Cross and 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 and Blue Shield of Georgia automatic debit process and will only occur each time I send a check to Blue Cross and 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.
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 at least 18 years of age; 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. If I purchase the optional BlueChoice® Dental coverage, I understand that I will have a six month waiting period for coverage of Basic Dental Care and a twelve month waiting period for coverage of Major Dental Care. (For a description of Preventive and Diagnostic, Basic, and Major Dental Care services please refer to your marketing materials.)
10. If the plan I purchase offers a maternity rider, and I purchase that maternity rider, I understand that 1) these benefits apply only to me, my covered spouse or my covered domestic partner and not to any dependent child and 2) these benefits will not begin until after my membership has been in effect for 12 months.
11. 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).
12. I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I hereby represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief, and understand these said answers and statements form the basis upon which insurance will be made effective. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission, or cancellation of my coverage(s).

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

Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance containing any materially false information or conceals, for the purpose of intentionally misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I hereby acknowledge that Blue Cross and Blue Shield of Georgia (BCBSGA) has informed me of the following prior to my enrollment in their health care coverage plan:

- number, mix and location of participating/network health care providers
- limitations of choices of participation/network health care providers
- disclosure of contractual relationship between participation/network provider and BCBSGA.

I give this authorization for and on behalf of any eligible dependents and myself if covered by Blue Cross and Blue Shield of Georgia. I am acting as their agent and representative.

This application may only be altered solely by the applicant or with his or her written consent.

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)

Section L – Agent Certification

To be completed by your Blue Cross-Appointed Agent.

List Bill ID Number (if applicable)

1. Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting? ☐ Yes ☐ No
2. Did you see the proposed subscriber (and spouse/domestic partner, if applying) at the time this application was executed? ☐ Yes ☐ No

   If NO, please explain: _____
3. **I certify to the best of my knowledge and belief, the responses herein are accurate.**

Agent Signature **X**			Date
Agent Name (please print)	Agent Street Address Suite No.Personal Mail Box (PMB) No.		
Agent ID No.	City/State/Zip	County Code	Area
Agent Phone No. / Agent Fax No.	Agent Email Address		

Authorization for Use of Protected Health Information

The following authorization must be signed by all of the following persons if they are applying for coverage or changing existing coverage:

- the applicant;
- the applicant's spouse or domestic partner; and
- any Dependent Child age 18 or over.

If the authorization is not signed by all of the persons listed above who are seeking coverage, the application may be returned to you as incomplete or acted upon without regard to any person whose required signature was not included. This Authorization will expire 24 months following Blue Cross and Blue Shield of Georgia's acceptance of coverage, if not previously revoked.

By signing below:

I authorize Blue Cross and Blue Shield of Georgia (BCBSGA), or an agent, subsidiary or affiliate that has a business associate contract with BCBSGA, to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, MIB, Inc., formerly Medical Information Bureau (MIB), and/or insurance support organizations. I further authorize BCBSGA to disclose protected health information it may collect about me to MIB, which may re-disclose such information to other insurance companies pursuant to the MIB information exchange.

I also authorize any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans, medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations to furnish any medical records or health history information concerning me and any family member listed on my Application to BCBSGA, or an agent, subsidiary or affiliate that has a business associate contract with BCBSGA. This information is needed to determine eligibility for coverage and BCBSGA's acceptance of coverage requested for myself and/or any family members listed on my Application or so that a determination of coverage regarding a claim for specified benefits can be made.

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 a legal representative signs on behalf of the applicant or spouse or domestic partner, a copy of the legal representative's authority must be attached to the application.

Legal Representative (please print full name)	Legal Relationship to Individual
Signature X	Date

A photocopy of this form will be as valid as the original. You or an authorized representative have the right to receive a copy of this Authorization upon request.

Conditional Receipt

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

Blue Cross and 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 waive 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 and Blue Shield of Georgia Customer Service at (800) 718-8831 or 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 and Blue Shield of Georgia Customer Service at (800) 718-8831 or Post Office Box 7368, Columbus, Georgia 31908-7368.