



INDIVIDUAL PRODUCT ENROLLMENT APPLICATION



INDIVIDUAL PRODUCT ENROLLMENT APPLICATION



APPLICANT SOCIAL SECURITY NO.

3350 Peachtree Road • Atlanta, GA 30326

Please Print Clearly • Use Black Ink Only

Type of Contract: Individual Family (Applicant must be oldest adult member)

SEX <input type="checkbox"/> M <input type="checkbox"/> F	LAST NAME	FIRST NAME	M.I.	HEIGHT	WEIGHT
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

AGE	BIRTHDATE Month/Day/Year	SOCIAL SECURITY NO.	MARITAL STATUS	REQUESTED EFFECTIVE DATE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="text"/>

Has anyone listed on this application ever been covered by Blue Cross and Blue Shield of Georgia or Blue Cross Blue Shield Healthcare Plan of Georgia? YES NO If yes, under what member ID# _____ . Dates From _____ to _____

RESIDENCE ADDRESS

STREET ADDRESS

CITY STATE ZIP CODE

HOME PHONE NO. (REQUIRED) DAYTIME PHONE NO. (REQUIRED)

E-MAIL ADDRESS

COUNTY

Is your home inside the city limits? YES NO

BILLING ADDRESS

STREET ADDRESS OR P.O. BOX

CITY STATE ZIP CODE

PLAN SELECTION

Blue Value Select PPO <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> Consumer Choice Option FlexPlus <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	Blue Value PPO <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> Consumer Choice Option Right Plan PPO <input type="checkbox"/> Right Plan Zero Deductible <input type="checkbox"/> Consumer Choice Option	Other Medical Plans <input type="checkbox"/> HSA Compatible/HDHP PPO <input type="checkbox"/> Consumer Choice Option Individual HDHP PPO 80% Coinsurance \$ _____ (Deductible) 100% Coinsurance \$ _____ (Deductible) Family HDHP PPO 80% Coinsurance \$ _____ (Deductible) 100% Coinsurance \$ _____ (Deductible)	Additional Coverage <input type="checkbox"/> Mental Health Rider <input type="checkbox"/> Dental <input type="checkbox"/> Blue Vision <input type="checkbox"/> High <input checked="" type="checkbox"/> Mid <input type="checkbox"/> Low <input type="checkbox"/> Term Life
---	--	---	---

Billing Type: Monthly Bank Draft - *First month check, credit or cash required, draft to begin second month.*
 (Note: Complete Bank Draft Authorization on page 5)
ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BLUE CROSS AND BLUE SHIELD OF GEORGIA

Credit Card Information First Month Only: MC Visa Discover Credit Card # _____ Exp. Date _____ month/year
 Name as it appears on Credit Card _____

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

FOR INTERNAL USE	DCN	LIST BILL	ACN
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SALES AGENT USE ONLY						
REP. NO.	CTY. CODE	AREA	DEDUCTIBLE	MTHLY PREMIUM	AGENT SIGNATURE	E-MAIL ADDRESS:
				AMT RECEIVED	PRINT NAME:	FAX NO.:

APPLICANT SOCIAL SECURITY NO.

Will you or any dependents on this application have any other medical coverage after this policy is effective? YES NO

Who is covered? Self Spouse Family Insurance Effective Date: --

Policy Holder Name: _____ Birth Date: --

Policy Number: _____ Insurance Company Name/Address: _____

After coverage begins, will you or any dependents have Medicare/Medicaid? (check one) YES NO

Are you eligible for Medicare? YES NO Part A Effective Date -- Part B Effective Date --

Is your spouse eligible for Medicare? YES NO Part A Effective Date -- Part B Effective Date --

MEDICARE HIC# Is Medicare coverage related to end stage renal disease? YES NO

If this is an application for a Family Contract, list all eligible dependents. This includes spouse and all unmarried, dependent children, stepchildren, or legally adopted children under age 19 or as otherwise mandated by state law. List dependents in order of age, beginning with the oldest. NOTE: if not a biological parent, complete CERTIFICATE OF DEPENDENCY form.

RELATION	SEX	HEIGHT	WEIGHT	AGE	BIRTHDATE Month/Day/Year	SOCIAL SECURITY NO.	FULL-TIME STUDENT	BIOLOGICAL CHILD?
Spouse	<input type="checkbox"/> M	LAST NAME <input type="text"/>					<input type="text"/> - <input type="text"/> - <input type="text"/>	
	<input type="checkbox"/> F	FIRST NAME <input type="text"/> M.I. <input type="text"/>						
Child	<input type="checkbox"/> M	LAST NAME <input type="text"/>					<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Yes
	<input type="checkbox"/> F	FIRST NAME <input type="text"/> M.I. <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> No					
Child	<input type="checkbox"/> M	LAST NAME <input type="text"/>					<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Yes
	<input type="checkbox"/> F	FIRST NAME <input type="text"/> M.I. <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> No					
Child	<input type="checkbox"/> M	LAST NAME <input type="text"/>					<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Yes
	<input type="checkbox"/> F	FIRST NAME <input type="text"/> M.I. <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> No					
Child	<input type="checkbox"/> M	LAST NAME <input type="text"/>					<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Yes
	<input type="checkbox"/> F	FIRST NAME <input type="text"/> M.I. <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> No					
Child	<input type="checkbox"/> M	LAST NAME <input type="text"/>					<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Yes
	<input type="checkbox"/> F	FIRST NAME <input type="text"/> M.I. <input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> No					

APPLICANT SOCIAL SECURITY NO.					

MEDICAL INFORMATION

HEALTH QUESTIONS: All of the following questions must be answered with respect to each person for whom you are applying for coverage. Indicate if anyone listed on this application EVER had medical advice, treatment, or if you have reasons to know of health problems in regard to the following, then check YES or NO to each question. Questions answered "yes" must be explained in detail, listing physicians' information in the space provided.

- | | |
|--|---|
| <p>(A) Yes No</p> <p>1. <input type="checkbox"/> <input type="checkbox"/> Impairment of Sight, Speech or Hearing</p> <p>2. <input type="checkbox"/> <input type="checkbox"/> Eyes, Ears, Nose, Throat, Head or Brain Disorder</p> <p>3. <input type="checkbox"/> <input type="checkbox"/> Disease of Endocrine System, Thyroid, Goiter or Diabetes</p> <p>4. <input type="checkbox"/> <input type="checkbox"/> Asthma, Sinus, Nasal, Allergies or Lung Disorder</p> <p>5. <input type="checkbox"/> <input type="checkbox"/> High or Low Blood Pressure, Heart Trouble or Vascular Disease</p> <p>6. <input type="checkbox"/> <input type="checkbox"/> Spine Condition or Bodily Deformity</p> <p>7. <input type="checkbox"/> <input type="checkbox"/> Disease of Bones or Joints, Arthritis or Rheumatism</p> <p>8. <input type="checkbox"/> <input type="checkbox"/> Ulcers or Stomach Disorders</p> <p>9. <input type="checkbox"/> <input type="checkbox"/> Kidney, Bladder or Prostate Disorder</p> <p>10. <input type="checkbox"/> <input type="checkbox"/> Gallbladder, Liver Disorder, or Hepatitis</p> <p>11. <input type="checkbox"/> <input type="checkbox"/> Menstrual Disturbances or other Female Disorders</p> <p>12. <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids, Intestinal or Rectal Disorder</p> <p>13. <input type="checkbox"/> <input type="checkbox"/> Hernia</p> <p>14. <input type="checkbox"/> <input type="checkbox"/> Nervous or Mental Disorder</p> <p>15. <input type="checkbox"/> <input type="checkbox"/> Fainting Attacks, Convulsions, or Epilepsy</p> | <p>Yes No</p> <p>16. <input type="checkbox"/> <input type="checkbox"/> Substance Abuse, Drug or Alcohol Abuse</p> <p>17. <input type="checkbox"/> <input type="checkbox"/> Blood Disorder, Anemia, Leukemia, or Hemophilia</p> <p>18. <input type="checkbox"/> <input type="checkbox"/> Tumor, Cyst or Cancer</p> <p>19. <input type="checkbox"/> <input type="checkbox"/> Is anyone listed on this application currently pregnant, in the process of adoption, or becoming a surrogate mother?</p> <p>20. <input type="checkbox"/> <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Kaposi Sarcoma, Pneumocystis Carinii Pneumonia, or Antibodies to Human T-Lymphotropic Virus Type III (HTLV-III)</p> <p>21. <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted diseases such as syphilis, gonorrhea, herpes, or genital warts</p> <p>22. <input type="checkbox"/> <input type="checkbox"/> Any other medical or surgical advice or treatments, hospitalizations, or chronic or recurring minor ailments.</p> <p>23. <input type="checkbox"/> <input type="checkbox"/> Do you now or have you ever, or anyone you are applying for, ever used tobacco products?</p> |
| <p>(B) Has any person listed on the application:</p> <p>1. <input type="checkbox"/> <input type="checkbox"/> Ever been advised to undergo a surgical operation which was not performed?</p> <p>2. <input type="checkbox"/> <input type="checkbox"/> Been advised to undergo surgery within the next six months?</p> | <p>(B) 3. <input type="checkbox"/> <input type="checkbox"/> Been refused or had health insurance cancelled?</p> <p>4. <input type="checkbox"/> <input type="checkbox"/> Ever had medical advice, treatment or any known indications of health problems not mentioned in the questions <i>above</i>?</p> |

NAME AND COMPLETE ADDRESS OF DOCTOR(S) SEEN BY APPLICANT WITHIN LAST 2 YEARS

NAME AND COMPLETE ADDRESS OF DOCTOR(S) SEEN BY SPOUSE WITHIN LAST 2 YEARS

NAME AND COMPLETE ADDRESS OF PEDIATRICIAN(S) SEEN BY ANY CHILDREN LISTED ON THIS APPLICATION WITHIN LAST 12 MONTHS

List below full details to questions answered "YES" in Sections A and B. If doctor has been seen in the last 2 years, give reason for visit. If additional space is needed, list on a separate sheet of paper and attach to this application.

Health Question #	Person Treated	Name of Illness or Disorder	Type of Treatment Received	Treatment Dates		Name & Address of Attending Physician or Pediatrician
				From	To	

Prescription Medications - List all medications taken within the last 12 months by any family member listed on this application. If additional space is needed, list on a separate sheet of paper and attach to this application.

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name, Phone No. of Prescribing Physician
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____

APPLICANT SOCIAL SECURITY NO.									

GREATER GEORGIA LIFE INSURANCE COMPANY
TERM LIFE INSURANCE COVERAGE SELECTION AND BENEFICIARY

Family Member To Be Insured	Birthdate mm/dd/yyyy	Amount of Benefit	Beneficiary Name	Beneficiary Social Security Number	Relationship	Allocation	% allocation
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000		- -		Primary Contingent	%
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000		- -		Primary Contingent	%
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000		- -		Primary Contingent	%
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000		- -		Primary Contingent	%

Note: The \$50,000 amount is not available to applicants under the age of 20. If selected by an approved applicant under the age of 20, the selection will default to \$25,000. If a beneficiary is not listed and Policy is issued, death benefits will be paid according to the Beneficiary Provision in the Policy.

I, the undersigned, hereby apply for the coverage indicated for myself and my eligible family members. I understand and agree that coverage will not be effective, nor will Blue Cross and Blue Shield of Georgia (BCBSGA) have any liability, unless and until this application is accepted and approved by Medical Underwriting, and a contract issued with identification cards showing effective dates. I understand that BCBSGA may require a physical examination of anyone listed on this application. BCBSGA reserves the right to change the premium charges due for this coverage by giving sixty (60) days written notice to the subscriber. I declare that all statements made hereon are complete and true to the best of my knowledge and belief, and agree that BCBSGA may cancel the coverage in its entirety or for any covered individual, if fraudulent or intentionally misleading information has been submitted, personally assuming liability for reimbursement to BCBSGA for any benefit payment made on behalf of any such family member. Ineligible persons may be removed at any time. After this contract has been in force for a period of two years during the lifetime of the insured, it shall become incontestable as to the misstatements in the application.

- I understand and agree that under this contract:
- When issued, will replace and supersede all similar contracts which may have been issued previously by BCBSGA or any of its affiliates
 - No agent has the authority to bind coverage or waive the answer to any question in this application, to pass insurability, to waive any of BCBSGA's rights or requirements or to make or alter any contract
 - Until coverage for a Member enrolled under this Contract has been in force for twelve (12) consecutive months, benefits for services to be paid by BCBSGA, shall not be available for any illness, injury, or other condition for which: medical advice, diagnosis, care, or treatment was recommended or received, within the previous twelve (12) months preceding the Effective Date of coverage. Applicants must meet medical underwriting requirements in order to obtain coverage. Certain medical conditions may be excluded from the Contract for specific time periods as determined by medical underwriting
 - If you have selected term life coverage, you are submitting this application and providing the information on this application to the underwriting department of Greater Georgia Life Insurance Company (GGL).

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 understand by signing this application and applying for term life insurance I am submitting this application and providing information on this application to the underwriting department of GGL.

Check the appropriate box:
 I DO UNDERSTAND I DO NOT UNDERSTAND

Applicant's Signature _____ Date _____ Spouse's Signature _____ Date _____
 (If family policy)



APPLICANT SOCIAL SECURITY NO.									

BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS

I hereby authorize **Blue Cross and Blue Shield of Georgia, Inc.** to draw checks, drafts, orders or electronic funds transfer on the 5th day of each month (EFT) upon my account at the:

_____	_____
NAME OF BANK	CHECKING ACCOUNT NUMBER
_____	_____
STREET ADDRESS OF BANK	CITY, STATE, ZIP CODE OF BANK

for the purpose of paying premiums on insurance issued by Blue Cross and Blue Shield of Georgia, Inc.

I understand if any check, draft, order or EFT transmission is returned due to **payment stopped** or **authorization cancelled**, this will be considered as my request to be billed directly.

_____	_____
CONTRACT HOLDER'S NAME	SOCIAL SECURITY NUMBER
_____	_____
CONTRACT HOLDER'S ADDRESS	CITY, STATE, AND ZIP CODE
_____	X _____
PRINTED SIGNATURE OF ACCOUNT HOLDER	SIGNATURE OF ACCOUNT HOLDER

	DATE

NOTE: A VOIDED CHECK MUST BE ATTACHED TO THIS APPLICATION.

First request for bankdraft plan

Complete entire form and attach a voided check.

INSTRUCTIONS FOR COMPLETING THE BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS

Automatic Premium Payment Plan

What is it - A special arrangement for payment of premiums automatically each month to relieve you of concern with due dates and the possibilities of having your insurance lapse unintentionally.

Who can use it - Bankdraft is an extra convenience for you. It is available if you maintain a regular checking account at your bank and make arrangements with your bank to honor automatic checks and electronic fund transfers.

How it works - To initiate the bankdraft, you must complete the authorizations above.

INSTRUCTIONS

1. Complete as follows:

- A. Fill in the name of your bank, branch, branch number (*if any*) and the city or state in which the bank or the branch is located.
- B. Print the name of your account exactly as it appears on your bank statement or check.
- C. Include your checking account number. It will usually be found below the signature line of your personal checks.
- D. Sign your name exactly as you do on your personal checks. If there is more than one depositor, all should sign.
- E. Include the date you signed the authorizations.

2. Attach a VOIDED check and this completed form. Please be sure the sample check is drawn on the same account as will be used for the automatic premium payment plan.

3. The coverage provided by this policy may be terminated by you upon thirty (30) days **written** notice.

4. Written notice thirty (30) days in advance as stated above in No. 3 is preferred. However, if any check is returned for **payment stopped** or **authorization cancelled**, this will be considered as your request to be billed directly. No further checks will be presented for payment to your bank. If a draft is returned for any other reason, you will be notified by Blue Cross and Blue Shield of Georgia of what is required to pay the premium.

INTERNAL USE ONLY

DCN #: _____
BANK #: _____



Instructions for Completing the BCBSGA Conditioned Authorization to Use or Disclose Protected Health Information for Enrollment in a Health Plan

This instruction sheet has been created to assist you in completing the Blue Cross and Blue Shield of Georgia (BCBSGA) "Conditioned Authorization for Use or Disclosure of Protected Health Information for Enrollment in a Health Plan" form. This form is used to authorize BCBSGA, its agents or subsidiaries, to use or disclose your Protected Health Information (PHI) for the purposes stated on the form. These instructions are designed to complement the information and instructions on the actual authorization form.

- General instructions:
 - Each family member over the age of 18 must individually sign (authorize) Blue Cross and Blue Shield of Georgia (BCBSGA) to obtain medical information that may be necessary to support their enrollment in a BCBSGA health care insurance product. This form and instructions are designed to assist in supporting this effort should it be required.
 - If you are unsure of how to complete any entry, after reading this form, please ask a BCBSGA Customer Care Associate, your Agent / Broker or the BCBSGA Associate that is assisting with the enrollment process for assistance.
- Specific instructions:
 - Please date the form in the space provided. This should be the same date as entered on your application. In the space to the right of the date, please enter the Social Security Number of the applicant or contract holder.
 - For each member over the age of 18, please print the name of the applicant, spouse or dependent on the applicable line on the left-hand side of the form.
 - After printing each individual's name, please have each individual sign in the corresponding space on the right hand side of the form. The signature should be in the same format as that used on your enrollment application.
 - In the event more dependents exist than the space provided, please copy the original enrollment form prior to signature, and repeat the process outlined above. The forms should be labeled, in the upper right hand corner: Page 1 of 2, Page 2, of 2 etc.
 - Date the form (or each form) in the space provided.
- Legal representative: If your legal representative or guardian completes the form on your behalf, they should sign and date the authorization in the block shown and attach documentation supporting their status as your legal representative (e.g., Health Care Power of Attorney, court order, proof of legal custody or guardian status, etc.).
- Please make a copy of this authorization and retain it in your records. Then include the completed authorization form in your enrollment package or provide it to the Broker / Agent or the BCBSGA Associate that is assisting you with the enrollment process.



Conditioned Authorization to Use or Disclose Protected Health Information for Enrollment in a Health Plan

Please print clearly and use only black ink.

By signing below, I authorize Blue Cross and 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.

Date: _____

Enter Applicant Social Security Number

Printed name of Applicant

Signature of Applicant or Applicant's Personal Representative

Printed name of Spouse or Dependent Child over age 18 listed on Application

*Signature of Spouse or Dependent Children over age 18 listed on the Application**

Printed name of Dependent Child over age 18 listed on Application

*Signature of Dependent Child**

Printed name of Dependent Child over age 18 listed on Application

*Signature of Dependent Child**

**If listed on your application, your spouse and each dependent child over age 18 must sign above.*

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 (print full name): _____

Legal relationship to individual: _____

Signature: _____ Date: _____

Please Keep A copy of this Conditioned Authorization Form for your Records

