

MEMBER ENROLLMENT APPLICATION (1)



PLEASE PRINT CLEARLY • USE BLACK INK ONLY

TYPE COVERAGE APPLIED FOR BCBSHP <input type="checkbox"/> BlueChoice Healthcare Plan (HMO) <input type="checkbox"/> BlueChoice Option (POS) BCBSGA <input type="checkbox"/> BlueChoice PPO <input type="checkbox"/> Dental Only <input type="checkbox"/> Traditional Health Plan Consumer Choice <input type="checkbox"/> HMO (BCBSHP) <input type="checkbox"/> PPO (BCBSGA) <input type="checkbox"/> POS (BCBSHP) GGL <input type="checkbox"/> Life Only EMPLOYMENT STATUS: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Cobra DATE OF EMPLOYMENT <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> EFFECTIVE DATE OF COVERAGE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> COMPANY DIV./PAY LOCATION <input type="checkbox"/> Hourly <input type="checkbox"/> Salary	GROUP NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> SUB <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> COMPANY NAME <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> EMPLOYEE HOME ADDRESS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> CITY <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> STATE ZIP CODE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> COUNTY HOME PHONE BUSINESS PHONE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> After coverage begins, will you or any dependents have any other medical insurance including Medicare? (check one) <input type="checkbox"/> YES <input type="checkbox"/> NO After coverage begins, will you or any dependents have any other dental insurance? (check one) <input type="checkbox"/> YES <input type="checkbox"/> NO Insurance Co. Name: _____ Policy No: _____ Insurance Co. Address: _____ Insurance Eff. Date: <input type="text"/> <input type="text"/> <input type="text"/> Policyholder Name: _____ Policyholder Date of Birth: <input type="text"/> <input type="text"/> <input type="text"/> Who is covered Self Spouse Family Is your spouse eligible for Medicare? <input type="checkbox"/> Part A / Effective Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> Part B / Effective Date <input type="text"/> <input type="text"/> <input type="text"/> Is Medicare coverage related to end stage renal disease? <input type="checkbox"/> YES <input type="checkbox"/> NO Is anyone listed on this application currently covered by Blue Cross and Blue Shield of Georgia? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Are you eligible for Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Part A / Effective Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> Part B / Effective Date <input type="text"/> <input type="text"/> <input type="text"/> MEDICARE HIC # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> REFUSED COVERAGE FOR: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life
	Complete the following information on you and your family members. If you elect BlueChoice Healthcare Plan or BlueChoice Option, please select a primary care physician. <input type="checkbox"/> <input checked="" type="checkbox"/> If you are an existing patient
	EMPLOYEE LAST NAME <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> FIRST <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MI <input type="text"/> DATE OF BIRTH <input type="text"/> <input type="text"/> <input type="text"/> SOCIAL SECURITY NO. <input type="text"/> <input type="text"/> <input type="text"/> PRIMARY CARE PHYSICIAN NAME _____ PHYSICIAN I.D. NO. <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> If you are an existing patient SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE ARE YOU APPLYING FOR DENTAL INS.? <input type="checkbox"/> YES <input type="checkbox"/> NO MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED

SPOUSE LAST NAME <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> FIRST <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MI <input type="text"/> DATE OF BIRTH <input type="text"/> <input type="text"/> <input type="text"/> SOCIAL SECURITY NO. <input type="text"/> <input type="text"/> <input type="text"/> PRIMARY CARE PHYSICIAN NAME _____ PHYSICIAN I.D. NO. <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> If you are an existing patient SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE ARE YOU APPLYING FOR DENTAL INS.? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> If you are an existing patient

CHILD LAST NAME <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> FIRST <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MI <input type="text"/> DATE OF BIRTH <input type="text"/> <input type="text"/> <input type="text"/> SOCIAL SECURITY NO. <input type="text"/> <input type="text"/> <input type="text"/> PRIMARY CARE PHYSICIAN NAME _____ PHYSICIAN I.D. NO. <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> If you are an existing patient SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE ARE YOU APPLYING FOR DENTAL INS.? <input type="checkbox"/> YES <input type="checkbox"/> NO COLLEGE STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO HANDICAPPED? <input type="checkbox"/> YES <input type="checkbox"/> NO
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CHILD LAST NAME <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> FIRST <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MI <input type="text"/> DATE OF BIRTH <input type="text"/> <input type="text"/> <input type="text"/> SOCIAL SECURITY NO. <input type="text"/> <input type="text"/> <input type="text"/> PRIMARY CARE PHYSICIAN NAME _____ PHYSICIAN I.D. NO. <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> If you are an existing patient SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE ARE YOU APPLYING FOR DENTAL INS.? <input type="checkbox"/> YES <input type="checkbox"/> NO COLLEGE STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO HANDICAPPED? <input type="checkbox"/> YES <input type="checkbox"/> NO
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COLLEGE STUDENT INFORMATION STUDENT'S FIRST NAME _____ DATE FIRST ATTENDED COLLEGE MO <input type="text"/> <input type="text"/> YR <input type="text"/> <input type="text"/> ANTICIPATED GRADUATION DATE MO <input type="text"/> <input type="text"/> YR <input type="text"/> <input type="text"/> NAME OF COLLEGE _____ STATE <input type="text"/> LIFE GROUP NO. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> SUB/LOC <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> EFFECTIVE DATE <input type="text"/> <input type="text"/> <input type="text"/> EMPLOYEE JOB TITLE _____ CLASS _____ SALARY/EARNINGS (IF APPLICABLE) \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUAL <input type="checkbox"/> OTHER Primary Beneficiary Last Name, First, M.I. _____ Relationship _____ Contingent Beneficiary Last Name, First, M.I. _____ Relationship _____

GREATER GEORGIA LIFE INSURANCE COMPANY	BASIC LIFE/AD&D <input type="checkbox"/> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % <input type="checkbox"/> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % DEP. LIFE SPOUSE <input type="checkbox"/> YES <input type="checkbox"/> NO DEP. LIFE CHILD <input type="checkbox"/> YES <input type="checkbox"/> NO STD <input type="checkbox"/> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % <input type="checkbox"/> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> % LTD MONTHLY <input type="checkbox"/> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	COVERAGE TYPE OF ACCOUNT APPLIED FOR
	1. _____ Relationship _____ 2. _____ Relationship _____
	2. _____ Relationship _____ 2. _____ Relationship _____

Medical Information

COMPLETE THIS SECTION FOR 2-19 EMPLOYEES AND FOR ALL LATE ENTRANTS.

Has anyone listed on this application ever been covered by Blue Cross and Blue Shield of Georgia? Yes No Member # _____

SECTION A

HEALTH QUESTIONS: All of the following questions must be answered with respect to each person for whom you are applying for coverage. (A) Has anyone listed on this application EVER had medical advice, treatment or do you know or have reasons to know of health problems in regard to the following? CHECK YES or NO. This information will be used to evaluate medical risk, not eligibility for coverage.

Yes No

- a. NERVOUS-Brain disease; stroke, epilepsy-seizures, fainting or dizzy spells; cerebral palsy; other nervous system disorders.
- b. PSYCHIATRIC-Psychiatric counseling; marriage counseling; family therapy; addiction to narcotics, barbiturates, amphetamines, or other drug dependency; nervous or mental disorders; alcoholism.
- c. GENITOURINARY SYSTEM-Kidney, prostate, bladder, menstrual or other female disorders.
- d. MUSCULOSKELETAL-Arthritis; rheumatism, bodily deformity; congenital abnormality; ruptured disc; or any muscle disorders.
- e. CARDIOPULMONARY-High blood pressure; heart disease; circulatory disorders; disease; tuberculosis.
- f. DIGESTIVE SYSTEM-Mouth; ulcers; disease of stomach; gall bladder; colon or intestines; hernia; rectal disorders.
- g. EYE, EAR, NOSE, THROAT-Asthma; sinus; allergies; disease of nose or ears; disease of throat or tonsils; impairment of sight or hearing.
- h. INCAPACITATION-Physical handicaps; mental retardation; disabled or incapacitated as defined by Medicare.
- i. 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).
- j. Sexually transmitted diseases such as syphilis, gonorrhea, herpes, genital warts.
- k. Tumor or mass, cancer/liver disorders; hepatitis; thyroid disorders; blood disease; hemophilia; diabetes; skin disorders; infections or any other medical advice, examination, not disclosed above?
- l. Is anyone listed on this application pregnant?
If yes, when is the expected due date? _____
- m. Been advised to undergo a surgical operation or procedure within the next 6 months?
- n. Are you currently taking prescription drugs? If yes, please list on separate sheet and attach.

I have answered all questions correctly for every person listed on application.
Applicant's Signature

SECTION B

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

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

SECTION C

COMPLETE SECTION C FOR 20-99 EMPLOYEES.

1. Has anyone applying for coverage been treated for a serious illness (For Example: Cancer, Diabetes, Heart Disease, Cardiovascular Disease, AIDS or AIDS-related disease, Pregnancy, Mental/Nervous Disorder, Substance Abuse, or any illnesses related to a major body organ), been hospitalized, had surgery, **OR** incurred health-care claims in excess of \$7,500 in any of the last 12 months? Yes No

COMPLETE THIS SECTION IF ANY QUESTIONS WERE ANSWERED "YES" IN SECTION A OR C.

SECTION D

Person Treated	Name of Illness or Disorder	Type of Treatment Received	Treatment Dates		Name and Address of Attending Physician
			From	To	

IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE SHEET.

PLEASE READ REVERSE SIDE BEFORE SIGNING FOR CONDITIONAL RECEIPT AND PRIVACY INFORMATION.

IF YOU ARE APPLYING FOR COVERAGE AND PORTABILITY RULES APPLY, PLEASE FURNISH PROOF OF YOUR PRIOR COVERAGE WITH THIS APPLICATION.

I declare that all statements and information made hereon are complete and true to the best of my knowledge. I understand that any mis-statements or omissions may void all coverage applied for on any member on this application on a retroactive basis for up to two (2) years from the contract effective date.

By signing this line, I understand that a pre-existing condition exclusion may apply [except for BlueChoice Healthcare Plan (HMO) and in-network BlueChoice Option (POS)] up to twelve (12) months under the BCBSHP/BCBSGA contract, as defined in the benefit booklet.

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

- a. number, mix and location of participating/network health care providers
- b. limitations on choices of participating/network health care providers
- c. disclosure of contractual relationship between participating/network provider and BCBSGA/BCBSHP.

APPLICANT'S SIGNATURE _____

DATE SIGNED _____

RIGHTS AND OBLIGATIONS

I hereby apply for myself and my eligible family members for (a) the medical coverage specified in the Contract between my Employer and Blue Cross Blue and Shield of Georgia, Inc. and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., (hereinafter referred to as the Company) and (b) if so indicated, life insurance provided by the Group Insurance Contract issued by Greater Georgia Life Insurance Co. to my Employer.

I understand and agree that the effective date of coverage will be governed by the stipulations of the Group Application and the Master Group Contract under which this application is made. I understand that membership will continue according to the terms of the contract between my Employer and the Company. I hereby authorize my Employer to periodically deduct any charge due from me hereunder and to remit same to the Company along with any contribution due from Employer. I understand and agree that the Company reserves the right to change the subscription charges due for this coverage and to increase or decrease the benefits by giving sixty (60) days written notice to my Employer.

I hereby authorize any hospital, physician, psychiatrist, psychologist, counselor, psychiatric hospital or other provider, dispenser of prescription drugs, appliances, ambulance service or any person or any institution rendering services to me or members of my family if covered hereunder, to furnish to the Company and/or Greater Georgia Life Insurance Co. all requested information concerning treatment, advice, psychiatric care or medical care for previous or future conditions, illnesses or disabilities.

I declare that all statements made hereon including the information provided on the front of this application are complete and true to the best of my knowledge and belief, and agree that the Company may cancel this coverage within two (2) years from the effective date, for any ineligible family member or one on whom erroneous or false information has been submitted, personally assuming liability for reimbursement to the Company for any benefit payment made on behalf of such family member. After this contract has been in force for a period of two (2) years during the lifetime of the insured, it shall become incontestable as to the statements in the applications. I understand that I am responsible for giving notice to my Employer of any changes in my status and that of family members which affect coverage.

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 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. We are required by law to keep such data confidential. It will be seen only by our employees and authorized agents. This data may in certain circumstances be disclosed without your authorization. We may furnish such data to authorized federal or state agencies, consumer investigative service bureaus or others if part of our standard business practice or required by law.

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, Inc. or Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

The following information is requested for statistical purposes including the compilation of data indicating the incidence of specific disease, condition or treatment patterns. It is not required to process your application and you may decline to answer if you prefer. Please ✓ the category that best describes your ethnic background.

- American Indian / Alaskan Native Black / African American Mexican, Mexican American
 Asian, Asian-American, or Pacific Islander Puerto Rican Other Hispanic or Latin White (non-Hispanic)

Other

Primary Language

Secondary Language

Group Administrators: Please mail applications to P.O. Box 4445 Atlanta, GA. 30302

BlueChoice Healthcare Plan and BlueChoice Option are underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSHP). BlueChoice PPO, Traditional Health Plan and Dental Plan are underwritten by Blue Cross and Blue Shield of Georgia (BCBSGA). BCBSHP, BCBSGA and Greater Georgia Life (GGL) are independent licensees of the Blue Cross Blue Shield Association.