

# Georgia Individual Enrollment Application

**IMPORTANT:** If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Blue Cross and Blue Shield of Georgia or Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSHP), premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 206-0913. If you have questions about a previously submitted application, please call 1 (855) 837-8540.

**Please complete in blue or black ink only.**

## Section A – Coverage Information

### Application Type (select one):

- New Coverage                       Change policy coverage                       Add dependent(s) to current coverage
- Policy No. \_\_\_\_\_ Policy No. \_\_\_\_\_

### Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. The earliest Effective Date for the annual Open Enrollment period is the first day of the following Calendar Year. The actual Effective Date is determined by the date BCBSHP receives a complete application with the applicable premium payment.

**Applications can be received during the Open Enrollment period. Outside the Open Enrollment period referenced above, the applicant may still enroll if he/she has a qualifying event as defined below. Following a qualifying event, an applicant has 60 days to submit an application. In the case of a future Loss of Minimum Essential Coverage, applications may be submitted up to 30 days in advance of the qualifying event date.**

### Qualifying Events

**Please check the qualifying event:**

- Open Enrollment;
- Involuntary Loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;
- Loss of Minimum Essential Coverage due to dissolution of marriage/domestic partnership;
- Birth or adoption or placement for adoption or appointment of guardianship;
- Moved to a new exchange service area or immigration status changed to lawfully present;
- Other Qualifying Event: \_\_\_\_\_ (Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events).

**Please provide the date of the qualifying event** (which includes the date of Loss of Minimum Essential Coverage): \_\_\_\_\_

If you are applying due to a qualifying event and your application is approved, your effective date is as follows:

- In the case of birth, adoption or placement for adoption or appointment of guardianship, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship; or
- In the case of marriage, or Loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application; or
- In the case of all other qualifying events, when the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. When the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month.

### Section B – Applicant Information

Last Name		First Name		MI	Social Security Number* (required)
Home Address					
City		State	ZIP	County	
Billing Address (street and P.O. Box if applicable)					
City		State	ZIP		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		
Primary Phone Number ( )	Secondary Phone Number ( )		E-mail		

*\*BCBSHP is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

### Section C – Spouse or Domestic Partner to be Covered Information

Last Name		First Name		MI	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner
Social Security Number* (required)		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth / /	

**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's or your Domestic Partner's children (to the end of the calendar month in which they turn age 26). (List all dependents beginning with the eldest.)

Last Name	First Name	MI	Sex	Date of Birth mm/dd/yyyy	Social Security Number* (required)	Relationship to Applicant
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____

*\*BCBSHP is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Are all applicants listed on this application legal residents of the United States and residents of the state in which you are applying for coverage?  Yes  No

If NO, who?

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Are all applicants listed on this application United States citizens, nationals or lawfully present non-citizens?  Yes  No

If NO, who?

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Are any of the applicants listed on the application currently incarcerated (except pending disposition of charges)?  Yes  No

If YES, who? \_\_\_\_\_

Has any applicant used tobacco products 4 or more times per week, on average, excluding religious or ceremonial usage in the last 6 months?  Yes  No

If YES, who?

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Preferred written language? (Optional)

English (ENG)

Spanish (SPN)

Preferred spoken language? (Optional)

English (ENG)

Spanish (SPN)

## Section E – Medical Coverage

### Plan Name and Deductible/Coinsurance Options

Select ONE Plan...then select ONE Individual Deductible/Coinsurance option.

Total Family Deductible is two (2) times the amount shown.

**BCBSHP Bronze Pathway HMO**

\$4,300/20% -(1G5K)

\$5,500/40% -(1G6J)

**BCBSHP Bronze Blue Open Access POS**

\$5,500/40% -(1G6Y)

\$5,750/30% -(1G6Z)

**BCBSHP Silver Pathway HMO**

\$2,000/20% -(1G69)

\$2,000/25% -(1G6Q)

\$3,000/10% -(1G63)

\$3,500/0% -(1G5R)

\$3,500/25% -(1G6V)

**BCBSHP Silver Blue Open Access POS**

\$2,250/30% -(1G71)

\$3,500/10% -(1G73)

\$3,500/25% -(1G74)

**BCBSHP Gold Pathway HMO**

\$1,150/10% -(1G6C)

**BCBSHP Catastrophic Pathway HMO (only available for Applicants under age 30 or otherwise qualified)**

\$6,600/0% -(1G5A)

### HSA Plans

**BCBSHP Bronze Pathway HMO 0% for HSA -(1G5D)**

**BCBSHP Bronze Pathway HMO 20% for HSA -(1G5G)**

**BCBSHP Bronze Pathway HMO 30% for HSA -(1G6F)**

**BCBSHP Bronze Blue Open Access POS 10% for HSA -(1G70)**

**BCBSHP Bronze Blue Open Access POS 30% for HSA -(1G6X)**

**BCBSHP Silver Pathway HMO 10% for HSA -(1G5X)**

**BCBSHP Silver Blue Open Access POS 10% for HSA -(1G72)**



## Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- I understand that although BCBSHP requires payment with my application, sending my initial premium with this application, and the receipt of my payment by BCBSHP, does not mean that coverage has been approved. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, BCBSHP 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.
- I am responsible to timely notify BCBSHP of any change that would make me or any dependent ineligible for coverage.
- I understand BCBSHP 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 BCBSHP automatic debit process and will only occur each time I send a check to BCBSHP. 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.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between BCBSHP and myself.
- I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 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.
- BY CHECKING THIS BOX, I AGREE TO RECEIVE ALL MAILINGS AND COMMUNICATIONS ELECTRONICALLY. SUCH ELECTRONIC MAILING OR COMMUNICATIONS MAY EVEN INCLUDE CANCELLATION OR NONRENEWAL NOTICES. I will be notified of such electronic communications at the email address I have provided on this application or by mail. I understand that I can revoke this authorization or request paper copies at any time free of charge by contacting BCBSHP customer service or online at [www.bcbsga.com](http://www.bcbsga.com).
- 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 BCBSHP in accepting this application. 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).
- As part of the W-9 Certification required by the Internal Revenue Service, I certify that the SSN number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

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

I hereby acknowledge that BCBSHP 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 BCBSHP.

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

<b>SIGN HERE</b>	Signature of Applicant* or Legal Representative X	Date
	Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
	Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

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

### Section I – Agent/Broker Certification

To be completed by your BCBSHP-appointed agent/broker:

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: \_\_\_\_\_

**I certify to the best of my knowledge and belief, the responses herein are accurate.**

Agent/Broker Signature <b>X</b>		Date	
Agent/Broker Name (please print) <b>Trevor Croley /ENROLLMENT</b>		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No. <b>PO BOX A</b>	
Agent/Broker ID/TIN <b>491869663</b>	Agency ID/Parent TIN	City <b>Springfield</b>	State <b>MO</b>
		ZIP <b>65808</b>	
Agent/Broker Phone No. <b>(417) 881-3520</b>	Agent/Broker Fax No. <b>(417) 881-4556</b>	Agent/Broker E-mail <b>tcroley@croleyinsurance.com</b>	
GA (if applicable)		GA code (if applicable)	

# Conditional Receipt

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

BCBSHP 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 BCBSHP, unless otherwise specifically stated, provided that the payment evidenced by this receipt is the full first month's dues and provided that BCBSHP 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 BCBSHP 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 Blue Shield Healthcare Plan of Georgia Customer Service at (855) 402-9635 or P.O. Box 105370, Atlanta, GA 30348-5370.

## 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; and
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 Healthcare Plan of Georgia Customer Service at (855) 402-9635 or P.O. Box 105370, Atlanta, GA 30348-5370.





Please mail this application to the following address:

**Blue Cross Blue Shield Healthcare Plan of Georgia  
PO BOX 659806  
SAN ANTONIO, TX 78265-9106**

Or

**Fax to: 1 (800) 848-2512**

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield name and symbol is a registered mark of the Blue Cross and Blue Shield Association.

