GEORGIA BANKERS ASSOCIATION INSURANCE TRUST, INC. **ENROLLMENT CARD**

Please use black ink. Incomplete forms could delay coverage and insurance ID cards

EMPLOYEE SOCIAL SECURITY NUMBER ___ - ___ - ____ GENDER ☐ M ☐ F MARITAL STATUS ☐ S ☐ M ☐ D

EMPLOYEE NAME - FIRST _____ MI ___ LAST _____

EMPLOYEE HOME ADDRESS - STREET _____

CITY _____ STATE ___ ZIP _____ COUNTY _____

EMPLOYER (COMPANY) NAME _____ EMPLOYER CITY _____ BANK NUMBER _____

DATE OF BIRTH (MM-DD-YYYY) __ - __ - ____ DATE EMPLOYED __ - __ - ____ DATE FULL - TIME STATUS __ - __ - ____ ANNUAL BASE EARNINGS _____

ELIGIBLE FIRST OF THE MONTH FOLLOWING DATE OF FULL-TIME EMPLOYMENT OR AFTER EMPLOYER'S WAITING PERIOD IF APPLICABLE MINIMUM 30 HOURS REQUIRED

LIFE INSURANCE BENEFICIARY	RELATIONSHIP AND SOCIAL SECURITY NUMBER
FIRST NAME MIDDLE INITIAL LAST	

IMPORTANT - CHECK COVERAGES DESIRED

☐ **EMPLOYEE LIFE INSURANCE PLAN #**_____

☐ **DEPENDENT LIFE - CHOOSE ONE:** ☐ **BASIC $2,000 OR** ☐ **TOTAL OF $10,000**

☐ **LONG TERM DISABILITY**

☐ **DENTAL PLAN #** ☐ **EMPLOYEE ONLY** ☐ **EMP. / SPOUSE** ☐ **EMP. / CHILDREN** ☐ **EMP. / SPOUSE / CHILDREN**

☐ **MEDICAL PLAN - CHOOSE ONE:** ☐ **HMO PLAN #** ___ ☐ **POS PLAN #** ___ ☐ **PPO PLAN #** ___

CHOOSE COVERAGE LEVEL: ☐ **EMPLOYEE ONLY** ☐ **EMP. / SPOUSE** ☐ **EMP. / CHILDREN** ☐ **EMP. / SPOUSE / CHILDREN**

DECLINING HEALTH COVERAGE FOR EMPLOYEE AND/OR DEPENDENTS - If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the qualifying event.

Declined health coverage for:	☐	Employee	☐	Spouse	☐	Children	**Reason declined**	☐	other coverage	☐ other reason _____
Declined dental coverage for:	☐	Employee	☐	Spouse	☐	Children	**Reason declined**	☐	other coverage	☐ other reason _____

DEPENDENTS APPLYING FOR MEDICAL AND/OR DENTAL COVERAGE

SPOUSE

☐ M ☐ F LAST NAME _____ FIRST NAME _____ MI ___ DATE OF BIRTH (MM-DD-YYYY) __ - __ - ____ SOCIAL SECURITY NUMBER ___ - __ - ____

CHILD 1

☐ M ☐ F LAST NAME _____ FIRST NAME _____ MI ___ DATE OF BIRTH (MM-DD-YYYY) __ - __ - ____ SOCIAL SECURITY NUMBER ___ - __ - ____

Disabled ? ☐ Y ☐ N

CHILD 2

LAST NAME | DATE OF BIRTH (MM-DD-YYYY)

☐ M

FIRST NAME | MI | SOCIAL SECURITY NUMBER

☐ F

Disabled ? ☐ Y ☐ N

CHILD 3

LAST NAME | DATE OF BIRTH (MM-DD-YYYY)

☐ M

FIRST NAME | MI | SOCIAL SECURITY NUMBER

☐ F

Disabled ? ☐ Y ☐ N

CHILD 4

LAST NAME | DATE OF BIRTH (MM-DD-YYYY)

☐ M

FIRST NAME | MI | SOCIAL SECURITY NUMBER

☐ F

Disabled ? ☐ Y ☐ N

OTHER COVERAGE INFORMATION - COMPLETE IF ENROLLING IN MEDICAL AND OR DENTAL COVERAGE

After this coverage begins, will you or any members of your family be covered under another group's insurance plan? ☐ **Y** ☐ **N**

If yes, please complete the information below. If no, please skip this section.

NAME AND DATE OF BIRTH OF INSURED _____

NAME OF INSURANCE CARRIER _____

ADDRESS OF INSURANCE CARRIER _____

_____

INSURANCE POLICY NUMBER _____

Type of Plan ☐ Medical ☐ Dental ☐ Both

Type of Coverage ☐ Family ☐ Individual Only

Does this plan coordinate by Gender or Birthday rule? _____

If there is family coverage, please list family members covered under this plan:

_____

_____

SB476 ACKNOWLEDGEMENT

I understand that I am enrolling in a health care plan, which requires that health care services must be provided by participating providers. Failure to use a participating provider will result in reduced coverage or no coverage for services that I receive, and I will be fully responsible for any and all costs not covered by Blue Cross and Blue Shield of Georgia/Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSGA) (as applicable).

I have received a complete listing of participating providers. I understand that the participation status of any provider may change from time to time. It is my responsibility to verify that my health care provider is participating with BCBSGA/BCBSHP prior to receiving services. I may verify participation status via BCBSGA's Web site, www.bcbsga.com which is updated at least every 30 days. I may also verify status by contacting the customer service number listed on my member ID card.

As required by the State of Georgia regulations, the following is a summary of the financial arrangements with the health care providers who are participating in the BCBSGA/BCBSHP network:

1. Hospital providers are paid according to a contract which includes inpatient per diems, case rates, and discounted fee for service arrangements depending on specific services provided.
2. Physicians are paid discounted fee for service in accordance with a specific fee schedule, which has been provided to them as contracted.
3. Laboratory services are provided through a capitated per member per month flat fee.
4. Other ancillary services including home health, skilled nursing, and hospice are paid on a contracted fee schedule with per diems or per visit amounts.

By signing below, I acknowledge my understanding of these plan provisions and am enrolling in the coverages accordingly. I also certify that all the information on this form, including dependent information and other coverage information is accurate.

Signature **Date**