MEMBER ENROLLMENT (2) CHANGE FORM

BlueCross BlueShield of Georgia | BlueCross BlueShield Healthcare Plan of Georgia | Greater Georgia Life Insurance Company

MEMBER NO. | GROUP NO. | SUB | COMPANY NAME

LAST NAME | FIRST NAME | MI | EFFECTIVE DATE OF CHANGES LISTED BELOW

PRINT CLEARLY • USE BLACK INK ONLY

ADDRESS/NAME CHANGE

ADDRESS CHANGE
STREET ADDRESS
CITY | STATE | ZIP CODE

NAME CHANGE
LAST NAME | FIRST NAME | MI

CHANGE OF COVERAGE

TYPE OF COVERAGE CHANGE
☐ BlueChoice Healthcare Plan (HMO) (BCBSHP) ☐ BlueChoice Option (POS) (BCBSHP) ☐ BlueChoice PPO (BCBSGA) ☐ Traditional Health (BCBSGA) ☐ Dental (BCBSGA) ☐ Life (GGL)
☐ Consumer Choice (HMO) (BCBSHP) ☐ Consumer Choice (POS) (BCBSHP) ☐ Consumer Choice PPO (BCBSGA)

If changing coverage to an HMO or POS plan, you must select a primary care physician (PCP) for each covered dependent in the spaces provided below.

TRANSFER TO ANOTHER GROUP NUMBER NEW GROUP NO. | SUB

COVERAGE TRANSFER EFFECTIVE DATE EFFECTIVE DATE

TRANSFER FROM AN EXISTING BCBSGA POLICY I would like to transfer from BCBSGA Policy MEMBER ID to BCBSGA Policy MEMBER ID

ADD DEPENDENTS
PLEASE CHECK REASON FOR ADDITION AND FILL IN THE APPROPRIATE SPOUSE AND/OR CHILDREN INFORMATION BELOW.
☐ MARRIAGE ☐ BIRTH ☐ ADOPTION ☐ COURTS
☐ OPEN ENROLLMENT ☐ LOSS OF COVERAGE ☐ COBRA
☐ OTHER (PLEASE EXPLAIN): ____________________

EMPLOYEE

PCP NAME | PHYSICIAN I.D. NO. | ☐ (✓) IF YOU ARE AN EXISTING PATIENT

ARE YOU APPLYING FOR DENTAL INS.? ☐ **YES** ☐ **NO**

SPOUSE

LAST NAME | FIRST | MI | DATE OF BIRTH
SOCIAL SECURITY NO. | PCP NAME | PHYSICIAN I.D. NO. | ☐ (✓) IF YOU ARE AN EXISTING PATIENT
SEX ☐ MALE ☐ FEMALE **ARE YOU APPLYING FOR DENTAL INS.?** ☐ **YES** ☐ **NO**

Please complete a Certification of Dependency form if the dependent children are not the biological children of either the applicant, spouse or both.

CHILD

LAST NAME | FIRST | MI | DATE OF BIRTH
SOCIAL SECURITY NO. | PCP NAME | PHYSICIAN I.D. NO. | ☐ (✓) IF YOU ARE AN EXISTING PATIENT
SEX ☐ MALE ☐ FEMALE **ARE YOU APPLYING FOR DENTAL INS.?** ☐ **YES** ☐ **NO**
COLLEGE STUDENT? ☐ YES ☐ NO (Attach Proof From College) HANDICAPPED? ☐ YES ☐ NO (Attach handicapped dependent certification)

CHILD

LAST NAME | FIRST | MI | DATE OF BIRTH
SOCIAL SECURITY NO. | PCP NAME | PHYSICIAN I.D. NO. | ☐ (✓) IF YOU ARE AN EXISTING PATIENT
SEX ☐ MALE ☐ FEMALE **ARE YOU APPLYING FOR DENTAL INS.?** ☐ **YES** ☐ **NO**
COLLEGE STUDENT? ☐ YES ☐ NO (Attach Proof From College) HANDICAPPED? ☐ YES ☐ NO (Attach handicapped dependent certification)

CHILD

LAST NAME | FIRST | MI | DATE OF BIRTH
SOCIAL SECURITY NO. | PCP NAME | PHYSICIAN I.D. NO. | ☐ (✓) IF YOU ARE AN EXISTING PATIENT
SEX ☐ MALE ☐ FEMALE **ARE YOU APPLYING FOR DENTAL INS.?** ☐ **YES** ☐ **NO**
COLLEGE STUDENT? ☐ YES ☐ NO (Attach Proof From College) HANDICAPPED? ☐ YES ☐ NO (Attach handicapped dependent certification)

GREATER GEORGIA LIFE INSURANCE CHANGES/ADDITIONS

Primary Beneficiary Last Name, First, M.I.	Relationship	Contingent Beneficiary Last Name, First, M.I.	Relationship
1.	1.	1.	1.
2.	2.	2.	2.

ATTN: SIGNATURE REQUIRED ON BACK OF FIRST PAGE

(PLEASE SEE REVERSE SIDE FOR OPTIONAL STATISTICAL QUESTIONS AND PRIVACY INFORMATION)

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 and Blue 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 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 my Employer. I understand and agree that the Company reserves the right the change the subscription charges due for this coverage and to increase or decrease the benefits by giving thirty (30) 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 of 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 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. We are required by law to keep such data confidential. It will be seen only by 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., and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

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 misstatements 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 and in-network BlueChoice Option) 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** _____

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 return change forms 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.