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 (BCBSGA), 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 Policy No._____ ☐ Add dependent(s) to current coverage 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 Initial Open Enrollment is January 1, 2014. For applications received after December 15, 2013, the Effective Date for the initial Open Enrollment period is the first day of the following month if receipt of application and premium is between the 1st and 15th of the month. If receipt of application and premium is after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (example: application with premium receipt is January 20th, your effective date is March 1st).

Applications must be received during the Open Enrollment period. Outside the above Open Enrollment period referenced above, the applicant may still enroll if he/she has a qualifying event as defined below. Notice of a qualifying event must be received by BCBSGA within 31 days of the qualifying event.

Qualifying Events

Please check the qualifying event:

☐ 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;

☐ Marriage/Domestic Partnership;

☐ Adoption or placement for adoption or appointment of guardianship;

☐ Birth.

Please provide the date of the qualifying event: _____

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.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*

Home Address (street and P.O. Box if applicable)			

City	State	ZIP	County

Billing Address (street and P.O. Box if different from above)		

City	State	ZIP

Marital Status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of Birth / /

Primary Phone Number ( )	Secondary Phone Number ( )	E-mail*

**This information is used for internal purposes only and will not be disclosed.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner

Social Security Number*	Sex ☐ M ☐ F	Date of Birth / /

**This information is used for internal purposes only and will not be disclosed.*

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 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*	Relationship to Applicant
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____

**This information is used for internal purposes only and will not be disclosed.*

Preferred written language? (Optional)

☐ Spanish (SPN)

☐ English (ENG)

Preferred spoken language? (Optional)

☐ Spanish (SPN)

☐ English (ENG)

Section E – Dental Coverage

Select ALL THAT APPLY:

☐ BCBSGA Dental Pediatric ☐ BCBSGA Dental Adult ☐ BCBSGA Dental Family
☐ BCBSGA Dental Adult Enhanced ☐ BCBSGA Dental Family Enhanced

Please note: the BCBSGA Dental Adult and BCBSGA Dental Adult Enhanced do not include pediatric coverage.

Important: You must enroll in pediatric dental coverage unless you will be enrolled in a standalone dental plan that has been certified by a state Exchange. To determine if your standalone dental plan has been certified by a state Exchange, please refer to your health plan enrollment information or the website for your state Exchange.

☐ Please check if you will be enrolled in a standalone dental plan meeting this requirement.

Section F – Other Dental Coverage

Do you, or anyone applying for coverage, currently have dental care coverage? ☐ Yes ☐ No

If YES, please provide the following:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage

Will you be cancelling this coverage if approved for BCBSGA coverage? ☐ Yes ☐ No

If **YES**, what is the cancellation date? _____

Section G – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- I understand that although BCBSGA requires payment with my application, sending my initial premium with this application, and the receipt of my payment by BCBSGA, 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, BCBSGA 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 BCBSGA of any change that would make me or any dependent ineligible for coverage.
- I understand BCBSGA 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 BCBSGA automatic debit process and will only occur each time I send a check to BCBSGA. 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 BCBSGA and myself.
- I understand I am applying for individual dental 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 authorize and expressly consent that BCBSGA and its affiliated companies may send e-mail communications instead of sending communications by mail, including but not limited to legally required Plan Notices and underwriting, enrollment and billing and explanation of benefits statements, to the e-mail address I have provided on this Application. I understand that I can revoke this authorization or request paper copies at any time free of charge by contacting BCBSGA customer service or online at 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 BCBSGA 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 or cancellation of my coverage(s).

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

I hereby acknowledge that BCBSGA has informed me of the following prior to my enrollment in their dental 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.

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

SIGN HERE	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 H – Agent/Broker Certification

To be completed by your BCBSGA-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 X			Date
Agent/Broker Name (please print)		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No.	
Agent/Broker ID/TIN	Agency ID/Parent TIN	City State ZIP	
Agent/Broker Phone No.	Agent/Broker Fax No.	Agent/Broker E-mail	
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.

BCBSGA has received from the named Applicant an advance deposit equal to the first month's dues together with an application for designated dental 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 BCBSGA, unless otherwise specifically stated, provided that the payment evidenced by this receipt is the full first month's dues and provided that BCBSGA 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 BCBSGA 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 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 of Georgia
PO BOX 659806
SAN ANTONIO, TX 78265-9106

Or

Fax to: 1 (800) 848-2512

Payment Methods for Individual Applications – Georgia

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Automatic Premium Payment (complete Section A)

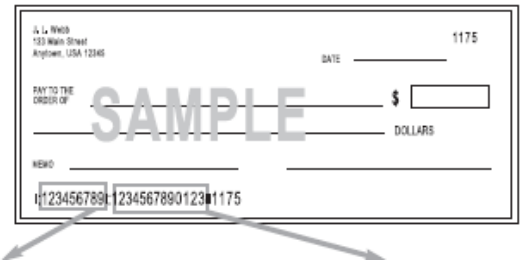
☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account

☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)



Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize Blue Cross and Blue Shield of Georgia to pay and charge to my account checks drawn on that account by and made payable to the order of Blue Cross and Blue Shield of Georgia, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Blue Cross and Blue Shield of Georgia of which I am notified pursuant to my plan/policy. I agree that Blue Cross and Blue Shield of Georgia's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Blue Cross and Blue Shield of Georgia to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing Blue Cross and Blue Shield of Georgia a 30-day written notice. I agree that Blue Cross and Blue Shield of Georgia shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, Blue Cross and Blue Shield of Georgia shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Blue Cross and Blue Shield of Georgia's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Blue Cross and Blue Shield of Georgia to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Blue Cross and Blue Shield of Georgia of which I am notified pursuant to my plan/policy. I agree that Blue Cross and Blue Shield of Georgia shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, Blue Cross and Blue Shield of Georgia shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. Blue Cross and Blue Shield of Georgia **accepts Visa and MasterCard.**

Card Number:	Expiration Date:

Billing address for this Credit / Debit Card:	City:	Zip Code:

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize Blue Cross and Blue Shield of Georgia either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Blue Cross and Blue Shield of Georgia uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.