BlueCross BlueShield Healthcare Plan of Georgia

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 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 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 ☐ Single ☐ Married	Sex ☐ M ☐ 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 ☐ Spouse ☐ Domestic Partner
Social Security Number* (required)	Sex ☐ M ☐ 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 ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ 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?

_____

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

If **NO**, who?

_____

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?

_____

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)**

☐ **YES**, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to BCBSHP's banking partner. (Please fill in your social security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to BCBSHP's banking partner.

Section F – Dental Coverage

☐ **Yes, I wish to purchase additional dental coverage to supplement the pediatric Essential Health Benefits to age** 19 **which are included in the medical plans above.**

Select All that Apply:

☐ BCBSGA Dental Family -(1FS1) ☐ BCBSGA Dental Family Enhanced -(1FS2)

Select who you are enrolling (applies to individuals listed on this application only):

☐ Applicant only
☐ Applicant & Spouse or Domestic Partner only
☐ Applicant & all dependent children listed
☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

Section G – Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, who? _____

Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits? ☐ Yes ☐ No

If **YES**, who and reason:

_____

_____

Start date of benefits/coverage: ____/____/_____ End date of benefits/coverage: ____/____/_____

Do you, or anyone applying for coverage, currently have health 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 BCBSHP coverage? ☐ Yes ☐ No

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

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.
- 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.

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 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 **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.

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

Payment Methods for Individual Applications – Georgia

BlueCross BlueShield Healthcare Plan of 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 BlueCross BlueShield Healthcare Plan of Georgia to pay and charge to my account checks drawn on that account by and made payable to the order of BlueCross BlueShield Healthcare Plan 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 BlueCross BlueShield Healthcare Plan of Georgia of which I am notified pursuant to my plan/policy. I agree that BlueCross BlueShield Healthcare Plan 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 BlueCross BlueShield Healthcare Plan 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 BlueCross BlueShield Healthcare Plan of Georgia a 30-day written notice. I agree that BlueCross BlueShield Healthcare Plan 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, BlueCross BlueShield Healthcare Plan of Georgia shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should BlueCross BlueShield Healthcare Plan 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 BlueCross BlueShield Healthcare Plan 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 BlueCross BlueShield Healthcare Plan of Georgia of which I am notified pursuant to my plan/policy. I agree that BlueCross BlueShield Healthcare Plan 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, BlueCross BlueShield Healthcare Plan 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. BlueCross BlueShield Healthcare Plan 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 BlueCross BlueShield Healthcare Plan 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 BlueCross BlueShield Healthcare Plan 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.