



**Member Enrollment Application (2)
Large Group 51-99**

How To Complete Your Enrollment Application

1. Use black ink only and print clearly.
2. Your employer may offer one or more health plans. Decide which health plan is best for you and/or your family before you complete your enrollment application.
3. If you decide that one of the Consumer Choice Options is the best for you and/or your family, please carefully read the enclosed brochure entitled, “Consumer Choice Option.” The information contained in this brochure will help you complete the correct form for enrollment (Applies to fully insured groups and to employees residing in the State of Georgia only).
4. After coverage begins, if you or any of your dependents will have other health insurance coverage, you must provide the insurance company name, effective date, policy number, address and other important information.
5. Sign and date your application.
6. If you have selected POS, PPO or Traditional Health Plan, please read the important information below about waiting periods.
7. If you refuse or decline coverage for any dependent, complete page three, “Notice of Special Enrollment Rights” and return the completed form to your Group Administrator.

Waiting Periods for Applicants of:

BlueChoice Option (POS), Blue Open Access POS, BlueChoice PPO HDHP PPO or Traditional Health Plan Upon receiving your application, we will review it and any certificates of prior coverage. Based on the information you submit, a waiting period for pre-existing condition(s) may apply to your coverage.

A pre-existing condition is any illness, injury or other condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the previous six months prior to your effective date in this Plan.

- **BlueChoice Option (POS), Blue Open Access POS:** During such a waiting period, no pre-existing conditions will be covered on your out-of-network benefits for the next 12 months.
- **BlueChoice PPO, HDHP PPO or Traditional Health Plan:** During such a waiting period, no pre-existing conditions will be covered on your in - or out - of - network benefits for the next 12 months (exception: Pregnancy).

If a waiting period is imposed and you disagree with the decision, please ask your employer for more information regarding previous coverage certification or call customer care at 1-800-441-2273. You may appeal the waiting period and provide additional evidence of prior coverage within 30-days of receiving written notification that a waiting period has in fact been imposed. Providers are compensated using a variety of payment arrangements, including fee for service, per diem, discounted fees, and global reimbursement.

Confidentiality Remains Our Priority

BCBSGa/BCBSHP remains committed to maintaining the confidentiality of our members' protected health information (PHI). PHI of any kind, including information about member medical care or health status, is protected by BCBSGa/BCBSHP confidentiality policies and procedures.

Data shared with employer groups cannot be implicitly or explicitly member-identifiable, unless specific member authorization has been obtained. These policies address confidentiality in many areas of our business, including:

- The Plan's routine uses and disclosures of PHI
- Use of Authorizations
- Access to PHI
- Internal protection of oral, written and electronic PHI across the Plan
- Protection of information disclosed to plan sponsors for employees
- The member's right to authorize or deny the release of PHI beyond treatment, payment or health care operations
- Use of the Plan's Web site as a means to communicate its confidentiality practices
- Information included in member's routine and special consent
- Access and release of medical records
- Protection of privacy in all settings
- Use of measurement data
- Building security
- Electronic claims handling
- Employee responsibility
- Corporate integrity.

All confidential PHI is treated with care and protected against unauthorized disclosure. BCBSGa/BCBSHP preserves the confidentiality of our members' personal and medical information in accordance with current statutory, regulatory and accreditation requirements.

Plan Practices for Maintaining Privacy and Data Security require that:

- All associates sign a statement ensuring that any information learned about a member will be held in confidence. These forms are required to be signed upon employment and annually thereafter.
- Access to information is controlled and limited to personnel who have an appropriate and approved need.
- Confidential information obtained for the purpose of ensuring, measuring and improving quality is housed in a specific department within the organization, with limited access to this information.
- Data shared with employer groups is not member-identifiable, unless members provide consent.
- All contracted providers, vendors and/or delegated entities agree to the Plan's confidentiality policies and procedures by submitting a written certification to BCBSGa/BCBSHP services, which contains strict confidentiality clauses.
- Except when such release is required by law, members may consent to, or refuse, the release of medical or other identifiable information by BCBSGa/BCBSHP.

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Notice of Special Enrollment Rights

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 31 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in the group's Certificate Booklet, which you may obtain from your employer.) 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 31 days after the marriage, birth, adoption, or placement for adoption.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the Plan based on a health status-related factor.

Complete If You Are Declining Coverage For Yourself Or Any Dependent:

If you are declining coverage for yourself or for any of your eligible dependents, you must complete the following information if you want to preserve your rights of special enrollment as explained above. If you decline coverage for yourself, the reason is:

I have other coverage **Spousal Group Coverage** **Another reason**

If you decline coverage for one or more eligible dependents, give the dependent's name below and indicate the reason coverage is declined.

Name _____ **Dependent has other coverage** **Another reason**

Name _____ **Dependent has other coverage** **Another reason**

Name _____ **Dependent has other coverage** **Another reason**

Name _____ **Dependent has other coverage** **Another reason**

Employee Name - Please Print

Employee Social Security Number

Employee Signature

____ / ____ / ____
Date

Please return this form to your company's Group Administrator.



EMPLOYEE SOCIAL SECURITY NO.

MEMBER ENROLLMENT APPLICATION (2) 51-99 Large Group

GROUP NUMBER

SUB

Company Div/Pay

 HOURLY SALARY

COMPANY NAME

EMPLOYEE NAME

LAST

FIRST

MI

GENDER

 M F

MARITAL STATUS

 SINGLE MARRIED DIVORCED

BIRTH DATE

MO DAY YEAR

EMPLOYEE MAILING ADDRESS

CITY

STATE ZIP

COUNTY

HOME PHONE

BUSINESS PHONE

REFUSED COVERAGE FOR: Medical Dental Life Vision

TYPE OF COVERAGE APPLIED FOR:

BCBSHP	BCBSGa	Consumer Choice	GGL
<input type="checkbox"/> HMO	<input type="checkbox"/> PPO	<input type="checkbox"/> HMO	<input type="checkbox"/> Life
<input type="checkbox"/> Blue Open Access HMO	<input type="checkbox"/> HDHP (HSA Compatible) PPO	<input type="checkbox"/> Blue Open Access HMO	<input type="checkbox"/> Short Term Disability
<input type="checkbox"/> POS	<input type="checkbox"/> HDHP (HRA) PPO	<input type="checkbox"/> POS	
<input type="checkbox"/> Blue Open Access POS	<input type="checkbox"/> Traditional (Indemnity)	<input type="checkbox"/> Blue Open Access POS	
	<input type="checkbox"/> Blue Vision	<input type="checkbox"/> PPO	
	<input type="checkbox"/> Dental	<input type="checkbox"/> HDHP (HSA Compatible) PPO	
	<input type="checkbox"/> EAP	<input type="checkbox"/> HDHP (HRA) PPO	

DATE OF EMPLOYMENT
MO DAY YEAREFFECTIVE DATE OF COVERAGE
MO DAY YEAR

EMPLOYMENT STATUS

 Active Retired
 COBRA DisabledPRIMARY CARE PHYSICIAN NAME AND ID NO.
(HMO & POS plans only) (✓) If you are an existing patient

PHYSICIAN NAME

ID NO.

OTHER INSURANCE INFORMATIONAfter coverage begins, will you or any dependents have any other medical insurance including Medicare? (check one) Yes No

Insurance Eff. Date:

MO DAY YEAR

Insurance Co. Name: _____

Policyholder Name: _____

Policy No: _____

Policyholder Date of Birth:

MO DAY YEAR

Insurance Co. Address: _____

Who is covered Self Spouse FamilyAre you eligible for Medicare? Yes NoIs your spouse eligible for Medicare? Yes No Part A / Effective Date MO DAY YEAR Part A / Effective Date MO DAY YEAR Part B / Effective Date MO DAY YEAR Part B / Effective Date MO DAY YEAR Part D / Effective Date MO DAY YEAR Part D / Effective Date MO DAY YEAR MEDICARE HIC # Is Medicare coverage related to end stage renal disease? Yes No

Complete the following information on you and your family members who are applying for coverage.

If you elect the HMO or POS plan, please select a primary care physician (does not apply to Blue Open Access).

Are the dependent children the biological children of either the applicant, spouse or both?

Yes No If no, please complete a Certification of Dependency form.

Relation	Gender	Name	Birthdate Month/Date/Year	Social Security No.	Primary Care Physician Name and ID No.
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ARE YOU APPLYING FOR: MEDICAL <input type="checkbox"/> Yes <input type="checkbox"/> No DENTAL <input type="checkbox"/> Yes <input type="checkbox"/> No LIFE <input type="checkbox"/> Yes <input type="checkbox"/> No VISION <input type="checkbox"/> Yes <input type="checkbox"/> No					
S P O U S E	<input type="checkbox"/> M <input type="checkbox"/> F	Last Name <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	MO DAY YEAR <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	SS# <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	<input type="checkbox"/> (✓) If you are an existing patient
		First Name M.I. <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	DOB <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	SS# <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	(Physician Name) <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>
					PCP ID Number <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>

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C H I L D	<input type="checkbox"/> M <input type="checkbox"/> F	Last Name <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	MO DAY YEAR <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	SS# <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	<input type="checkbox"/> (✓) If you are an existing patient
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COLLEGE STUDENT? Yes No If Yes, Date First Attended College ___ / ___ / ___ Anticipated Graduation Date ___ / ___ / ___
 If yes please add proof of full-time student status.
 Name of College _____ State _____

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C H I L D	<input type="checkbox"/> M <input type="checkbox"/> F	Last Name <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	MO DAY YEAR <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	SS# <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	<input type="checkbox"/> (✓) If you are an existing patient
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COLLEGE STUDENT? Yes No If Yes, Date First Attended College ___ / ___ / ___ Anticipated Graduation Date ___ / ___ / ___
 If yes please add proof of full-time student status.
 Name of College _____ State _____

ARE YOU APPLYING FOR: MEDICAL <input type="checkbox"/> Yes <input type="checkbox"/> No DENTAL <input type="checkbox"/> Yes <input type="checkbox"/> No LIFE <input type="checkbox"/> Yes <input type="checkbox"/> No VISION <input type="checkbox"/> Yes <input type="checkbox"/> No HANDICAPPED? <input type="checkbox"/> Yes <input type="checkbox"/> No					
C H I L D	<input type="checkbox"/> M <input type="checkbox"/> F	Last Name <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	MO DAY YEAR <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	SS# <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>	<input type="checkbox"/> (✓) If you are an existing patient
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COLLEGE STUDENT? Yes No If Yes, Date First Attended College ___ / ___ / ___ Anticipated Graduation Date ___ / ___ / ___
 If yes please add proof of full-time student status.
 Name of College _____ State _____

G r e a t e r G e o r g i a L i f e	EMPLOYEE JOB TITLE <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"></table>		T y p e o f C o v e r a g e	BASIC LIFE/ AD&D <input type="checkbox"/> \$ <table border="1" style="width: 60px; height: 20px; border-collapse: collapse;"></table>		SUPPLEMENT LIFE/ AD&D <input type="checkbox"/> \$ <table border="1" style="width: 60px; height: 20px; border-collapse: collapse;"></table>	
	SALARY/EARNINGS (if applicable) \$ <table border="1" style="width: 60px; height: 20px; border-collapse: collapse;"></table> <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUAL <input type="checkbox"/> OTHER			DEP. LIFE SPOUSE <input type="checkbox"/> YES <input type="checkbox"/> NO		DEP. LIFE CHILD <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Primary Beneficiary (Last Name, First, M.I.) Relationship			Contingent Beneficiary (Last Name, First, M.I.) Relationship			
1. _____ 1. _____ 2. _____ 2. _____		1. _____ 1. _____ 2. _____ 2. _____					

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Medical Information

COMPLETE SECTION A FOR ALL LATE ENTRANTS AND FOR GROUPS WITHOUT PRIOR GROUP COVERAGE.

Has anyone listed on this application ever been covered by Blue Cross and Blue Shield of Georgia? Yes No Prior Member # _____

HEALTH QUESTIONS: All of the following questions must be answered with respect to each person for whom you are applying for coverage. Within the last five years, has anyone listed on this application had medical advice, treatment or do you know or have reasons to know of health problems in regard to the following? CHECK YES or NO. This information will be used to evaluate medical risk, not eligibility for coverage.

Yes No

- a. **Nervous System:** brain disease, stroke, epilepsy-seizures, fainting or dizzy spells, cerebral palsy, other nervous system disorders.
- b. **Psychiatric:** psychiatric counseling, marriage counseling, family therapy, addiction to narcotics, barbiturates, amphetamines, or other drug dependency, nervous system or mental disorders, alcoholism.
- c. **Genitourinary System:** kidney, bladder, prostate, testicular, menstrual, uterine, ovarian or other male/female disorders.
- d. **Musculoskeletal System:** arthritis, rheumatism, bodily deformity, congenital abnormality, ruptured disc, bone disease or muscle disorders.
- e. **Cardiopulmonary Disease:** high blood pressure, heart disease, circulatory disorders, tuberculosis.
- f. **Digestive System:** diseases and/or ulcers of the mouth, esophagus, stomach, gall bladder, colon, intestines, hernia or rectal disorders.
- g. **Eye, Ear, Nose, Throat:** asthma, sinus, allergies, diseases of eyes, ears, or nose; diseases of throat or tonsils; impairment of sight or hearing.
- h. **Incapacitation:** physical handicaps, mental retardation, disabled or incapacitated as defined by Medicare.
- i. **Acquired Immune Deficiency Syndrome (AIDS):** AIDS-Related Complex (ARC), Kaposi Sarcoma, Pneumocystis Carinii Pneumonia, or Antibodies to Human T-Lymphotropic Virus Type III (HTLV-III).
- j. **Sexually transmitted diseases (STD):** such as syphilis, gonorrhea, herpes, genital warts.
- k. **Tumor or mass, cancer/liver disorders:** hepatitis, diabetes, thyroid disorders, blood disease, hemophilia, skin disorders, infections or any other medical advice, examination, not disclosed above?
- l. Is anyone listed on this application pregnant? If yes, when is the expected due date? _____
- m. Has any applicant been advised to undergo a surgical operation or procedure within the next 6 months?
- n. Is any applicant currently taking prescription drugs? If yes, please list on separate sheet and attach.

COMPLETE SECTION B FOR GROUPS WITH 51-99 EMPLOYEES.

In the last 12 months, has anyone applying for coverage been treated for a serious illness (For example: Cancer, Diabetes, Heart Disease, Cardiovascular Disease, AIDS or AIDS-related disease, Pregnancy, Mental/Nervous Disorder, Substance Abuse, or any illnesses related to a major body organ), been hospitalized, had surgery, OR incurred health-care claims in excess of \$7,500.

Yes No

COMPLETE SECTION C IF ANY QUESTIONS WERE ANSWERED "YES" IN SECTIONS A OR B.

Person Treated	Name of Illness or Disorder	Type of Treatment Received	Treatment Dates		Name and Address of Attending Physician
			From	To	

IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE SHEET.

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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 the 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 here under and to remit same to the Company along with any contribution due from Employer. I understand and agree that the Company reserves the right to change the subscription charges due for this coverage and to increase or decrease the benefits by giving sixty (60) 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 or one on whom erroneous or intentionally 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 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; 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 and Blue Shield of Georgia, Inc. or Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

BlueChoice Healthcare Plan, BlueChoice Option, Blue Open Access HMO/POS are underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSHP). BlueChoice PPO, HDHP (HRA) PPO, Traditional Health Plan, Blue Vision and Dental Plan are underwritten by BlueCross and Blue Shield of Georgia (BCBSGa). BCBSHP, BCBSGa and Greater Georgia Life (GGL) are independent licensees of the Blue Cross Blue Shield Association.

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

PLEASE READ THE CONFIDENTIALITY AND PRIVACY INFORMATION ON PAGE 2 BEFORE SIGNING THIS APPLICATION. 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 intentional 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.

EMPLOYEE SIGNATURE _____	DATE SIGNED _____
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