Georgia Short-Term PPO Enrollment Application

1. Please complete all pages of this application. 2. Print in blue or black ink or type. 3. Send completed application and payment to:
Blue Cross and Blue Shield of Georgia · Mail Stop GAG008-0005 · 3350 Peachtree Road, NE · Atlanta, GA 30326

Section A – Applicant Information (Applicant must be oldest adult member.)

Last Name	First Name	MI	Social Security Number*

Home Street Address (Must be completed: P.O. Box not acceptable)

City	State	Zip	County

Mailing Address (If different from above) or P.O. Box

City	State	Zip	County

Marital Status
☐ Single ☐ Married ☐ Domestic Partner

Are you a legal resident of the United States and a resident of the state of Georgia? ☐ Yes ☐ No

Evening Phone Number	Daytime Phone Number	E-mail Address*
( )	( )	If possible, do you want E-mail notification? ☐ Yes ☐ No

Section B – Plan Selections

Deductible (Individual/Family):
☐ $250/$500 ☐ $1,000/$2,000
☐ $500/$1,000 ☐ $2,500/$5,000

Policy Term (Number of Months):
☐ 1 month ☐ 3 months ☐ 5 months
☐ 2 months ☐ 4 months ☐ 6 months

Optional Coverage:
☐ Consumer Choice Option

Section C – Effective Date

If your application is approved your coverage can start on any day of the month after the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.

Please choose the date you would like your coverage to start: _____/_____/_____ (MM/DD/YYYY)

Section D – Applicants for Coverage

- ▶ Please list ALL applicants applying for coverage (including applicant listed in Section A). If a family member's last name is different than yours, please explain on a separate page.
- ▶ Newborn children under 30 days of age are not eligible for coverage.
- ▶ Dependents between the ages of 19 through 25 if a full-time student are eligible for coverage, or as otherwise mandated by state law.
- ▶ BCBSGA will enroll all eligible family members unless otherwise instructed below.
  ☐ I, the Applicant, request that Blue Cross and Blue Shield not enroll any eligible applicants unless ALL family members qualify.

First, MI (last name if different)	Social Security Number*	Sex	Date of Birth mm/dd/yyyy	Height Ft. / In.	Weight Lbs.	Full-Time Student?
Applicant		M F	/ /	/		Y N
Spouse/Domestic Partner		M F	/ /	/		Y N
Dependent		M F	/ /	/		Y N
Dependent		M F	/ /	/		Y N
Dependent		M F	/ /	/		Y N

**This information is used for internal purposes only.*

Note: Please make a copy of the signed application for your records prior to submitting to Blue Cross and Blue Shield of Georgia.

Section E – Health History (Answer the following questions completely and accurately.)

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

NOTE: If the answer to any question from 1-3 is YES, the policy cannot be issued for that applicant. Answering NO to questions 1-3 does not guarantee coverage. All answers will be validated and a brief review of claims history may be completed.

	YES	NO
1. a) Is any applicant pregnant, or in the process of adoption or surrogate pregnancy?	☐	☐
b) Is any applicant listed on this application an expectant parent, the child of an expectant parent, or in the process of adoption or surrogate pregnancy with anyone, whether or not the mother is listed on this application?	☐	☐
If YES, applicant(s) to whom question 1 applies: _____		
2. Within the past 5 years, have you or any person listed on this application received any medical or surgical consultation, advice or treatment, including medication for:		
a) heart or circulatory system disorder including heart attack or chest pain; stroke?	☐	☐
b) disorders of the blood, including hemophilia and leukemia; diabetes; cancer or tumor?	☐	☐
c) alcoholism or alcohol abuse; drug abuse or chemical dependency?	☐	☐
d) immune disorders; organ transplant; kidney or liver disorders?	☐	☐
If YES, applicant(s) to whom question 2 applies: _____		
3. Within the last 10 years, has any person listed on this application been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐
If YES, applicant(s) to whom question 3 applies: _____		

Section F – Payment and Billing Options

► **Please enter the monthly premium amount, number of months you would like coverage, and calculate the total premium below:**

_____ (Monthly Premium Amount) **X** _____ (No. of Months) **=** _____ (Total Policy Premium)

Initial Premium (required)

► **Please select your premium payment frequency:**

☐ Monthly ☐ Total Policy Premium

► **You may make your initial premium payment by sending a paper check with your application or by completing the credit card section below. If you have chosen monthly premium payments, they can be made by automatic bank draft or credit card; paper billing is not an option for this contract. Complete the appropriate sections below.**

☐ **AUTOMATIC BANK DRAFT** (automatic premium withdrawals to begin in the second month) – Your premium will be deducted on or about the 5th of each month. You may attach a **blank** voided check or complete the information below.

I authorize Blue Cross and Blue Shield of Georgia to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. I understand that this authorization is in effect until I notify Blue Cross and Blue Shield of Georgia that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand that Blue Cross and Blue Shield of Georgia and my financial institution have the right to discontinue the withdrawals if they wish to do so. I understand that a service charge will be incurred for any withdrawal not honored.

Account Holder Name (please print)	Name of Bank	Account Number
Account Holder Signature (if other than applicant) **X**	Routing Number	Account Holder's SSN

☐ **CREDIT CARD:** ☐ **Initial Premium** ☐ **Monthly Premium** ☐ **Initial and Monthly Premiums**

Credit card information (Your monthly premium will be charged to the account on or about the 5th of each month.)

Cardholder Name (as shown on the credit card)	Cardholder Address:

If the applicant is using the credit card of another cardholder: By signing this form, the applicant represents and warrants that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for the payments and any charges accruing to it.

Type of credit card: ☐ VISA ☐ MasterCard ☐ Discover	Credit Card Number:	Expiration Date (mm/yyyy):

Authorization: *I authorize Blue Cross and Blue Shield of Georgia to charge my Visa, MasterCard or Discover credit card for the initial premium payment. If the results of the health underwriting for my policy result in a different premium than the quote generated by the system, I also authorize Blue Cross and Blue Shield of Georgia to charge my Visa, MasterCard or Discover credit card for this difference if necessary.*

I agree that Blue Cross and Blue Shield of Georgia is fully protected in honoring any credit card payments. I further agree that if any credit card payment is dishonored, with or without cause, intentionally or inadvertently, Blue Cross and Blue Shield of Georgia is under no liability whatsoever, including any fees imposed by my bank, if my credit card is rejected even though such dishonor results in termination of coverage.

Applicant signature:
X

Note: Please make a copy of the signed application for your records prior to submitting to Blue Cross and Blue Shield of Georgia.

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

It is important that you carefully read and fully understand the following before signing the application.

By applying for coverage, I, the undersigned, agree to the following:

1. I understand that it is mandatory that I notify Blue Cross and Blue Shield of Georgia (BCBSGA), in writing, immediately if I (the applicant) or any other person for whom coverage is sought received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date or the date underwriting approves, whichever is later. I understand that in this situation, BCBSGA has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be rescinded, or delayed, or reformed or benefits denied due to the illness, injury or condition being treated as a preexisting condition.
2. Blue Cross and Blue Shield of Georgia (BCBSGA) may decline my application. No coverage comes into effect until BCBSGA approves this application and informs me in writing.
3. Cashing my check does not mean my application is approved. If this application is declined, neither BCBSGA nor any affiliated company shall have any liability to me or any one else listed on it, except for the obligation to return the money submitted with this application.
4. No agent has the authority to bind coverage or waive the answer to any question in this application, to pass insurability, to waive any of BCBSGA's rights or requirements or to make or alter any contract.
5. Any of my dependents listed on this application who are over the age of 18 years have read this application and have provided complete and accurate information for this application. Also, I have done everything necessary to be able to assure you that all information about any children under the age of 18 listed on this application is true and complete to the best of my knowledge and belief. I understand and agree that I alone am responsible for the accuracy and completeness of this application. I understand and agree that no one listed on this application will be eligible for coverage if any information is false or incomplete and that BCBSGA may revoke coverage if it discovers that any information on this application is incomplete or false.
6. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
7. I understand BCBSGA may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.
8. I acknowledge that I have read, or have had read to me, the completed application. I realize that if I omit any information or provide any fraudulent or, intentionally misleading or incomplete information that is considered fraud or material misrepresentation, this can result in claim denial and/or cancellation of this coverage. I agree to repay promptly any benefit payment to which my dependents or I was not entitled. I understand that the contract applied for will not provide benefits for any expenses incurred on account of any condition that manifested itself before the contract effective date, as explained in the "Exclusions " section of my contract. I also understand that this is not a continuation of any previous medical program, including any prior Short Term Medical contract.
9. I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 6 months or more; he or she is mentally competent; he or she, is at least 18 years old; 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.

I, the undersigned, hereby apply for the coverage indicated for my eligible family members and myself. I understand and agree that coverage will not be effective, nor will Blue Cross and Blue Shield of Georgia (BCBSGA) have any liability, unless and until this application is accepted and approved by Medical Underwriting, and a contract issued with identification cards showing effective dates. I understand that BCBSGA may require a physical examination of anyone listed on this application. BCBSGA reserves the right to change any applicable premiums for new coverage issued after the expiration date of this policy. I declare that all statements made hereon are complete and true to the best of my knowledge and belief, and agree that BCBSGA may cancel the coverage in its entirety or for any covered individual, if fraudulent or intentionally misleading information has been submitted, personally assuming liability for reimbursement to BCBSGA for any benefit payment made on behalf of any such family member. Ineligible persons may be removed at any time.

IF LISTED ON YOUR APPLICATION, YOUR SPOUSE/DOMESTIC PARTNER AND EACH DEPENDENT CHILD OVER AGE 18 MUST SIGN BELOW.

Signature of Applicant/Parent or Legal Guardian **X**	Date
Signature of Spouse or Domestic Partner **X**	Date
Signature of Dependent age 18 or over **X**	Date
Signature of Dependent age 18 or over **X**	Date
Signature of Dependent age 18 or over **X**	Date

Note: Please make a copy of the signed application for your records prior to submitting to Blue Cross and Blue Shield of Georgia.

Section H – Agent Certification

To be completed by your BCBSGA Appointed Agent.

1. Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting? . . . . . ☐ Yes ☐ No
2. Did you see the applicant (and spouse/domestic partner, if applying) at the time this application was executed? . . . . . ☐ Yes ☐ No
   If NO, please explain: _____
3. Total funds collected: . . . . . $ _____
4. **I certify to the best of my knowledge and belief, the responses herein are accurate.**

Agent Signature (required) **X**			Date (required)
Agent Name (please print)	Agent Street Address / Suite No. / Personal Mail Box (PMB) No.		
Agent ID No.	City/State/Zip	County Code	Area
Agent Phone No.	Agent Fax No.	Agent Email Address	

CONDITIONAL RECEIPT

THIS RECEIPT DOES NOT PROVIDE ANY COVERAGE UNTIL ALL THE TERMS AND CONDITIONS LISTED BELOW ARE MET.

Blue Cross and Blue Shield of Georgia (BCBSGA) has received from the named Applicant an advance deposit equal to at least the first month's premium 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 Medical Underwriting, unless otherwise specifically stated, provided that the payment evidenced by this receipt is the full first month's premium 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 waiver or modify any of the terms or conditions of this receipt.

If you do not receive a contract within 30 days, please contact Blue Cross and Blue Shield of Georgia Customer Service at (800)718-8831 or Post Office Box 7368, Columbus, Georgia 31908-7368.

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;
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 Customer Service at (800)718-8831 or Post Office Box 7368, Columbus, Georgia 31908-7368.

SUBMITTING YOUR APPLICATION

► **Please mail this application to:** **Blue Cross and Blue Shield of Georgia**
Mail Stop GAG008-0005
3350 Peachtree Road, NE
Atlanta, GA 30326

OR **Fax to:** **(404) 682-3237**
(866) 538-0824 Toll Free

► For information on eligibility, please call BCBSGA Customer Service (800)718-8831.

► Save time by applying online (if paying by credit card) at **www.bcbsga.com**.