Employee Change Form
For 2–50 Employee Small Groups
Georgia

Instructions:

If you are cancelling coverage for a dependent or changing a name, please provide a reason in the designated sections. Complete electronically, or in blue or black ink and return to your employer. Please use extra sheets of paper if necessary. NOTE: Some changes may be made by accessing bcbsga.com.

Section A: General Information

Employer name	Group no.		Employee life class
Employee last name	Employee first name	M.I.	Employee ID/HCID/Social Security no.

Section B: Employee Information – Required

Reason for change – Required. Check all that apply.

☐ Address change ☐ Add spouse/Domestic Partner or dependent ☐ Change life classification ☐ Cancel coverage
☐ Name change ☐ Cancel spouse/Domestic Partner or dependent ☐ Enrollment in Medicare (Fill in Section E)
☐ Benefit change ☐ Change Primary Care Physician (PCP) ☐ Other: ______________________

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ______________________

Event date/Requested effective date – Required ____________ (MM/DD/YYYY)

Home address – Street and PO Box if applicable	City	State	ZIP code

County	Birthdate (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Domestic Partner

Primary phone no.	Secondary phone no.	Email address

PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No

Section C: Family Information – Spouse and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ______________________

Event date/Requested effective date – Required ____________ (MM/DD/YYYY)

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.

Sex ☐ Male ☐ Female	Disabled? ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner

PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No

Does the spouse/Domestic Partner have a different address?
☐ Yes ☐ No If yes, please enter: ______________________

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

Life and Disability products are underwritten by Greater Georgia Life Insurance Company (GGL), independent licensee of the Blue Cross and Blue Shield Association.
Blue Cross and Blue Shield of Georgia, Inc. and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. are independent licensees of the Blue Cross and Blue Shield Association.
The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Employee name	Social Security no.

Section C: Family Information — Continued

☐ Add ☐ Change ☐ Cancel

Event reason — Required. Check all that apply.
☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ____________
Event date/Requested effective date — Required ____________ (MM/DD/YYYY)

Dependent last name	First name	M.I.	Social Security no.

Sex	Disabled?	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? ____________

PCP name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address?
☐ Yes ☐ No **If yes, please enter:** ____________

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

☐ Add ☐ Change ☐ Cancel

Event reason — Required. Check all that apply.
☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ____________
Event date/Requested effective date — Required ____________ (MM/DD/YYYY)

Dependent last name	First name	M.I.	Social Security no.

Sex	Disabled?	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? ____________

PCP name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address?
☐ Yes ☐ No **If yes, please enter:** ____________

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

☐ Add ☐ Change ☐ Cancel

Event reason — Required. Check all that apply.
☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ____________
Event date/Requested effective date — Required ____________ (MM/DD/YYYY)

Dependent last name	First name	M.I.	Social Security no.

Sex	Disabled?	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? ____________

PCP name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address?
☐ Yes ☐ No **If yes, please enter:** ____________

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

Employee name	Social Security no.

Section D: Plan/Type of Coverage

1. Medical Coverage

Enter network name, product plan name and contract code selected:

Network name	Product plan name	Contract code, if known

Note for Health Savings Account (HSA) enrollees:
If you enroll in an HSA plan, Anthem will facilitate the opening of a Health Savings Plan in your name, if directed by your employer.

Member medical coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

2. Dental Coverage

Product plan name	Contract code, if known

Member dental coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

3. Vision Coverage

☐ I am enrolling in my Employer's vision plan, if any.	Contract code, if known

Member vision coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

Section E: Other Group Coverage

Is anyone applying for coverage currently eligible for Medicare?
☐ Yes ☐ No

If yes, give name: ______________________________

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date __________

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date

Is anyone applying for coverage covered by other health coverage?
☐ Yes ☐ No

If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policy holder name	Dates (if applicable)
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:

Employee name	Social Security no.

Section F: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Blue Cross and Blue Shield of Georgia (BCBSGa) as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible dependent:

- Employee's spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that: I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide BCBSGa with information regarding my HSA. I hereby authorize the financial custodian to provide BCBSGa with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide BCBSGa with a written request to revoke my authorization at any time.

Coverage Option: If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, BCBSGa or by another carrier.

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. O.C.G.A. 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.

Sign here	Applicant signature X	Date (MM/DD/YYYY)