



Choose Your Plan.

Apply today to secure the health care coverage you deserve.

1. Complete all sections of this application.
2. Be sure to sign your name next to the "X".
3. Return your completed and signed application in the postage-paid envelope provided.

About you.

1 _____
 First name M.I. Last name

2 _____
 Street or Box No. City State Zip County

3 _____
 Your phone number Social Security No. Your Medicare number

4 _____
 Date of birth Age Male Female

5 How would you like to be billed?

- Monthly bill Monthly deduction from checking account

Whichever method of payment you choose, please include a check for the first month's premium made payable to Blue Cross and Blue Shield of Georgia.

6 Billing Type

- Credit Card Monthly Bank Draft - First month credit or cash required, draft to begin second month.
 (Note: Complete Bank Draft on page 7)

7 Credit Card Information

Type of Card: _____ Credit Card No. _____ Exp. Date: _____
 Name as it appears on Credit Card _____

8 You must be a Georgia resident, have Medicare Parts A &B, and be 65 or older to enroll.

Medicare Part A effective date _____ Medicare Part B effective date _____

9 All plans are guaranteed renewable.

Please indicate which Insurance Plan you wish to apply for by checking a box.

- Plan A Plan C Plan E Plan F SmartChoice SmartChoice Preferred Plan J

Check here to apply for the AdvantageCare Rider.

(You must complete section 12)

When would you like your policy to be effective? ____/____/____

(We need your application by the 25th for it to be effective on the 1st of the following month.)

Check here to enroll in our Senior Dental Plan

Your Acceptance May be Guaranteed. If you qualify for Guaranteed Issue Coverage (see Guaranteed Issue Guide), please answer the following question:

What situation do you qualify for under Guaranteed Issue? _____ (Situation Number)

Please include a copy of the required documentation with this application.

Broker / Agent - Complete Section Entirely

DCN		Group #		Effective Date
_____		_____		_____
Rep #	Cty. Code	Rate Cat. Quoted	Monthly Dues	Rep's Name (Please Print)
_____	_____	_____	_____	_____
			Amt. Rec'd	Rep's Signature
			_____	_____

Social Security #: _____

10 Are you covered by Blue Cross and Blue Shield health insurance now? Yes No

If yes, please give us the details of your plan:

Your Blue Cross and Blue Shield Group # _____ Contract # _____

The location of your Blue Cross and Blue Shield Plan: _____

City

State

11 If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

To the best of your knowledge:

A. Did you turn age 65 in the last 6 months? Yes No

B. Did you enroll in Medicare Part B in the last 6 months? Yes No

C. If yes, what is the effective date? _____ Yes No

D. Are you covered for medical assistance through the state Medicaid program? Yes No

NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.

If yes,

i. Will Medicaid pay your premiums for this Medicare supplement policy? Yes No

ii. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No

E. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ____/____/____ END ____/____/____

i. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No

ii. Was this your first time in this type of Medicare plan? Yes No

iii. Did you drop a Medicare supplement policy to enroll in this Medicare plan? Yes No

F. Do you have another Medicare supplement policy in force?

i. If so, with what company, and what plan do you have? _____ Yes No

ii. If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No

G. Have you had coverage under any other health insurance within the past 63 days? Yes No

(For example, an employer, union, or individual plan)

i. If so, with what company and what kind of policy? _____

ii. What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank. START ____/____/____ END ____/____/____

H. Are you enrolled in a Medicare Prescription Drug Plan (Part D)?

If so, fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START ____/____/____ END ____/____/____

12 If you are applying for coverage during open enrollment or during a Guaranteed Issue period, do not complete the following.

If the answers to any of the health questions are yes, you are not eligible for coverage.

1. Are you currently confined, or within the past two (2) years has confinement been recommended, to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair? Yes No

2. Within the past two (2) years, have you been advised to have kidney dialysis, joint replacement or surgery for the heart, arteries or intestines which has not yet been done? Yes No

Social Security #: _____

3. Within the past two (2) years, have you been hospitalized 2 or more times, or been confined to a nursing home for 2 weeks? (Total all confinements.) Yes No
4. Within the past two (2) years, have you been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for internal cancer, leukemia, Hodgkin's disease, coronary artery disease, heart attack, nephritis, kidney failure, stroke or brain disorder? Yes No
5. Within the past five (5) years, have you been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for: AIDS/ARC, Alzheimer's disease, senility, dementia, Parkinson's disease, Multiple Sclerosis, neuromuscular disorders, congestive heart failure, heart valve replacement, open heart surgery or angioplasty, organ transplant (except cornea), cirrhosis of the liver or complications of diabetes such as amputation or loss of sight? Yes No

13 Important information you must read

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid or may not need a Medicare supplement policy.
4. If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days after losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).



Instructions for Completing the BCBSGA Conditioned Authorization to Use or Disclose Protected Health Information for Enrollment in a Health Plan

This instruction sheet has been created to assist you in completing the Blue Cross and Blue Shield of Georgia (BCBSGA) "Conditioned Authorization for Use or Disclosure of Protected Health Information for Enrollment in a Health Plan" form. This form is used to authorize BCBSGA, its agents or subsidiaries, to use or disclose your Protected Health Information (PHI) for the purposes stated on the form. These instructions are designed to complement the information and instructions on the actual authorization form.

- General Instructions:
 - Each family member over the age of 18 must individually sign (authorize) Blue Cross Blue Shield of Georgia (BCBSGA) to obtain medical information that may be necessary to support their enrollment in a BCBSGA health care insurance product. This form and instructions are designed to assist in supporting this effort should it be required.
 - If you are unsure of how to complete any entry, after reading this form, please ask a BCBSGA Customer Care Associate, your Agent /Broker or the BCBSGA Associate that is assisting with the enrollment process for assistance.
- Specific Instructions:
 - Please date the form in the space provided. This date should be the same as entered on your application. In the space to the right of the date, please enter the Social Security
 - Number of the applicant or contract holder. For each member over the age of 18, please print the name of the applicant, spouse or dependent on the applicable line on the left-hand side of the form.
 - After printing each individual's name, please have each individual sign in the corresponding space on the right-hand side of the form. The signature should be in the same format as that used on your enrollment application.
 - In the event more dependents exist than the space provided, please copy the original enrollment form, prior to signature, and repeat the process outlines above. The forms should be labeled, in the upper right-hand corner: Page 1 of 2, Page 2 of 2, etc.
- Legal representative: If your legal representative or guardian completes the form on your behalf, they should sign and date the authorization in the block shown and attach documentation supporting their status as your legal representative (e.g., Health Care Power of Attorney, court order, proof of legal custody or guardian status, etc.).
- Please make a copy of this authorization and retain it in your records. Then include the completed authorization form in your enrollment package or provide it to the Broker /Agent or the BCBSGA Associate that is assisting you with the enrollment process.



**Conditioned Authorization to Use or Disclose
Protected Health Information for
Enrollment in a Health Plan**
Please print clearly and use only black ink.

By signing below, I authorize Blue Cross Blue Shield of Georgia (BCBSGA) to obtain any necessary medical records from any physicians, hospitals and/or any other health care providers concerning my care and the care of any family member listed on my Application. I understand this information will be used to determine whether my listed family members and I are eligible for enrollment in the coverage requested.

I understand that BCBSGA will not process my Application for enrollment unless this Authorization is signed and returned with my Application. This Authorization permits BCBSGA to request from health care providers any additional medical information needed to determine my eligibility for coverage and/or the eligibility of any family members listed on my Application. This Authorization will expire within one (1) year of the date indicated below.

I understand that I may revoke this authorization at any time during the application process by submitting a completed Authorization Revocation Form to BCBSGA. I may request an Authorization Revocation Form by contacting BCBSGA or the Broker /Agent assisting with my enrollment. If I revoke this authorization, I understand that I/we will not be considered by BCBSGA for enrollment in a health plan.

Date: _____

Enter Applicant Social Security Number

Printed name of Applicant

Signature of Applicant or Applicant's Personal Representative

Printed name of Spouse or Dependent Child over age 18 listed on Application

*Signature of Spouse or Dependent Children over age 18 listed on the Application.**

Printed name of Dependent Child over age 18 listed on Application

*Signature of Dependent Child**

Printed name of Dependent Child over age 18 listed on Application

*Signature of Dependent Child**

**If listed on your application, your spouse and each dependent child over age 18 must sign above.*

Designated Legal Representative /Guardian

If this form is signed by a legal representative /guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the ability of the legal representative to act on the individual's behalf, must be attached.

Legal representative (print full name): _____

Legal relationship to individual: _____

Signature: _____

Date: _____

Please Keep A Copy of this Conditioned Authorization Form for your Records

An Independent Licensee of the Blue Cross Blue Shield Association

