



If you checked blocks 6 or 11, answer ALL of the following questions with respect to each person for whom you are applying or upgrading benefits.

(A) Have any of the persons listed ever had medical advice, examination, treatment or any known indications of health problems in regard to the following:

- | <table border="0"> <tr> <th style="text-align: left;">Yes</th> <th style="text-align: left;">No</th> <td></td> <th style="text-align: left;">Yes</th> <th style="text-align: left;">No</th> </tr> <tr> <td>1. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Impairment of Sight, Speech or Hearing</td> <td>14. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Nervous or Mental Disorder</td> </tr> <tr> <td>2. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Eyes, Ears, Nose, Throat, Head or Brain Disorder</td> <td>15. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Fainting Attacks, Convulsions, or Epilepsy</td> </tr> <tr> <td>3. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Disease of Endocrine System, Thyroid, Goiter or Diabetes</td> <td>16. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Substance Abuse, Drug or Alcohol Abuse</td> </tr> <tr> <td>4. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Asthma, Sinus, Nasal, Allergies or Lung Disorder</td> <td>17. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Blood Disorder, Anemia, Leukemia, or Hemophilia</td> </tr> <tr> <td>5. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>High or Low Blood Pressure, Heart Trouble or Vascular Disease</td> <td>18. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Tumor, Cyst or Cancer</td> </tr> <tr> <td>6. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Spine Condition or Bodily Deformity</td> <td>19. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>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)</td> </tr> <tr> <td>7. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Disease of Bones or Joints, Arthritis or Rheumatism</td> <td>20. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sexually transmitted diseases such as syphilis, gonorrhea, herpes, genital warts</td> </tr> <tr> <td>8. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Ulcers or Stomach Disorders</td> <td>21. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Any other Medical or Surgical advice or treatments, hospitalizations, or chronic or recurring minor ailments.</td> </tr> <tr> <td>9. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Kidney, Bladder or Prostate Disorder</td> <td>22. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Do you now or have you ever, or anyone you are applying for, ever used tobacco products?</td> </tr> <tr> <td>10. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Gallbladder, Liver Disorder, or Hepatitis</td> <td>23. <input type="checkbox"/></td> <td><input 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Nose, Throat, Head or Brain Disorder | 15. <input type="checkbox"/> | <input type="checkbox"/> | Fainting Attacks, Convulsions, or Epilepsy | 3. <input type="checkbox"/> | <input type="checkbox"/> | Disease of Endocrine System, Thyroid, Goiter or Diabetes | 16. <input type="checkbox"/> | <input type="checkbox"/> | Substance Abuse, Drug or Alcohol Abuse | 4. <input type="checkbox"/> | <input type="checkbox"/> | Asthma, Sinus, Nasal, Allergies or Lung Disorder | 17. <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder, Anemia, Leukemia, or Hemophilia | 5. <input type="checkbox"/> | <input type="checkbox"/> | High or Low Blood Pressure, Heart Trouble or Vascular Disease | 18. <input type="checkbox"/> | <input type="checkbox"/> | Tumor, Cyst or Cancer | 6. <input type="checkbox"/> | <input type="checkbox"/> | Spine Condition or Bodily Deformity | 19. <input type="checkbox"/> | <input type="checkbox"/> | 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) | 7. <input type="checkbox"/> | <input type="checkbox"/> | Disease of Bones or Joints, Arthritis or Rheumatism | 20. <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted diseases such as syphilis, gonorrhea, herpes, genital warts | 8. <input type="checkbox"/> | <input type="checkbox"/> | Ulcers or Stomach Disorders | 21. <input type="checkbox"/> | <input type="checkbox"/> | Any other Medical or Surgical advice or treatments, hospitalizations, or chronic or recurring minor ailments. | 9. <input type="checkbox"/> | <input type="checkbox"/> | Kidney, Bladder or Prostate Disorder | 22. <input type="checkbox"/> | <input type="checkbox"/> | Do you now or have you ever, or anyone you are applying for, ever used tobacco products? | 10. <input type="checkbox"/> | <input type="checkbox"/> | Gallbladder, Liver Disorder, or Hepatitis | 23. <input type="checkbox"/> | <input type="checkbox"/> | Is any person listed on this application pregnant? | 11. <input type="checkbox"/> | <input type="checkbox"/> | Menstrual Disturbances or other Female Disorders | 24. <input type="checkbox"/> | <input type="checkbox"/> | Do any complications exist? | 12. <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids, Intestinal or Rectal Disorder |  |  |  | 13. <input type="checkbox"/> | <input type="checkbox"/> | Hernia |  |  |  | <table border="0"> <tr> <th style="text-align: left;">Yes</th> <th style="text-align: left;">No</th> </tr> <tr> <td>1. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Ever been advised to undergo a surgical operation which was not performed?</td> </tr> <tr> <td>2. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Been advised to undergo surgery within the next six months?</td> </tr> <tr> <td>3. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Been refused or had health insurance cancelled within last 5 years?</td> </tr> <tr> <td>4. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Is anyone listed on the application in impaired mental or physical health?</td> </tr> </table> | Yes | No | 1. <input type="checkbox"/> | <input type="checkbox"/> | Ever been advised to undergo a surgical operation which was not performed? | 2. <input type="checkbox"/> | <input type="checkbox"/> | Been advised to undergo surgery within the next six months? | 3. <input type="checkbox"/> | <input type="checkbox"/> | Been refused or had health insurance cancelled within last 5 years? | 4. <input type="checkbox"/> | <input type="checkbox"/> | Is anyone listed on the application in impaired mental or physical health? |
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| Yes  | No                       |  | Yes                          | No                       |   |                             |                          |  |                              |                          |                            |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |   |                             |                          |   |                              |                          |                       |                             |                          |                                     |                              |                          |   |                             |                          |   |                              |                          |  |                             |                          |                             |                              |                          |   |                             |                          |                                      |                              |                          |  |                              |                          |   |                              |                          |  |                              |                          |  |                              |                          |                             |                              |                          |  |  |  |  |                              |                          |        |  |  |  |   |     |    |                             |                          |  |                             |                          |   |                             |                          |   |                             |                          |  |
| 1. <input type="checkbox"/>  | <input type="checkbox"/> | Impairment of Sight, Speech or Hearing                                     | 14. <input type="checkbox"/> | <input type="checkbox"/> | Nervous or Mental Disorder  |                             |                          |  |                              |                          |                            |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |   |                             |                          |   |                              |                          |                       |                             |                          |                                     |                              |                          |   |                             |                          |   |                              |                          |  |                             |                          |                             |                              |                          |   |                             |                          |                                      |                              |                          |  |                              |                          |   |                              |                          |  |                              |                          |  |                              |                          |                             |                              |                          |  |  |  |  |                              |                          |        |  |  |  |   |     |    |                             |                          |  |                             |                          |   |                             |                          |   |                             |                          |  |
| 2. <input type="checkbox"/>  | <input type="checkbox"/> | Eyes, Ears, Nose, Throat, Head or Brain Disorder                           | 15. <input type="checkbox"/> | <input type="checkbox"/> | Fainting Attacks, Convulsions, or Epilepsy  |                             |                          |  |                              |                          |                            |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |   |                             |                          |   |                              |                          |                       |                             |                          |                                     |                              |                          |   |                             |                          |   |                              |                          |  |                             |                          |                             |                              |                          |   |                             |                          |                                      |                              |                          |  |                              |                          |   |                              |                          |  |                              |                          |  |                              |                          |                             |                              |                          |  |  |  |  |                              |                          |        |  |  |  |   |     |    |                             |                          |  |                             |                          |   |                             |                          |   |                             |                          |  |
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| 9. <input type="checkbox"/>  | <input type="checkbox"/> | Kidney, Bladder or Prostate Disorder                                       | 22. <input type="checkbox"/> | <input type="checkbox"/> | Do you now or have you ever, or anyone you are applying for, ever used tobacco products?  |                             |                          |  |                              |                          |                            |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |   |                             |                          |   |                              |                          |                       |                             |                          |                                     |                              |                          |   |                             |                          |   |                              |                          |  |                             |                          |                             |                              |                          |   |                             |                          |                                      |                              |                          |  |                              |                          |   |                              |                          |  |                              |                          |  |                              |                          |                             |                              |                          |  |  |  |  |                              |                          |        |  |  |  |   |     |    |                             |                          |  |                             |                          |   |                             |                          |   |                             |                          |  |
| 10. <input type="checkbox"/>   | <input type="checkbox"/> | Gallbladder, Liver Disorder, or Hepatitis                                  | 23. <input type="checkbox"/> | <input type="checkbox"/> | Is any person listed on this application pregnant?  |                             |                          |  |                              |                          |                            |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |   |                             |                          |   |                              |                          |                       |                             |                          |                                     |                              |                          |   |                             |                          |   |                              |                          |  |                             |                          |                             |                              |                          |   |                             |                          |                                      |                              |                          |  |                              |                          |   |                              |                          |  |                              |                          |  |                              |                          |                             |                              |                          |  |  |  |  |                              |                          |        |  |  |  |   |     |    |                             |                          |  |                             |                          |   |                             |                          |   |                             |                          |  |
| 11. <input type="checkbox"/>   | <input type="checkbox"/> | Menstrual Disturbances or other Female Disorders                           | 24. <input type="checkbox"/> | <input type="checkbox"/> | Do any complications exist?   |                             |                          |  |                              |                          |                            |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |   |                             |                          |   |                              |                          |                       |                             |                          |                                     |                              |                          |   |                             |                          |   |                              |                          |  |                             |                          |                             |                              |                          |   |                             |                          |                                      |                              |                          |  |                              |                          |   |                              |                          |  |                              |                          |  |                              |                          |                             |                              |                          |  |  |  |  |                              |                          |        |  |  |  |   |     |    |                             |                          |  |                             |                          |   |                             |                          |   |                             |                          |  |
| 12. <input type="checkbox"/>   | <input type="checkbox"/> | Hemorrhoids, Intestinal or Rectal Disorder                                 |                              |                          |   |                             |                          |  |                              |                          |                            |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |   |                             |                          |   |                              |                          |                       |                             |                          |                                     |                              |                          |   |                             |                          |   |                              |                          |  |                             |                          |                             |                              |                          |   |                             |                          |                                      |                              |                          |  |                              |                          |   |                              |                          |  |                              |                          |  |                              |                          |                             |                              |                          |  |  |  |  |                              |                          |        |  |  |  |   |     |    |                             |                          |  |                             |                          |   |                             |                          |   |                             |                          |  |
| 13. <input type="checkbox"/>   | <input type="checkbox"/> | Hernia   |                              |                          |   |                             |                          |  |                              |                          |                            |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |   |                             |                          |   |                              |                          |                       |                             |                          |                                     |                              |                          |   |                             |                          |   |                              |                          |  |                             |                          |                             |                              |                          |   |                             |                          |                                      |                              |                          |  |                              |                          |   |                              |                          |  |                              |                          |  |                              |                          |                             |                              |                          |  |  |  |  |                              |                          |        |  |  |  |   |     |    |                             |                          |  |                             |                          |   |                             |                          |   |                             |                          |  |
| Yes  | No                       |  |                              |                          |   |                             |                          |  |                              |                          |                            |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |   |                             |                          |   |                              |                          |                       |                             |                          |                                     |                              |                          |   |                             |                          |   |                              |                          |  |                             |                          |                             |                              |                          |   |                             |                          |                                      |                              |                          |  |                              |                          |   |                              |                          |  |                              |                          |  |                              |                          |                             |                              |                          |  |  |  |  |                              |                          |        |  |  |  |   |     |    |                             |                          |  |                             |                          |   |                             |                          |   |                             |                          |  |
| 1. <input type="checkbox"/>  | <input type="checkbox"/> | Ever been advised to undergo a surgical operation which was not performed? |                              |                          |   |                             |                          |  |                              |                          |                            |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |   |                             |                          |   |                              |                          |                       |                             |                          |                                     |                              |                          |   |                             |                          |   |                              |                          |  |                             |                          |                             |                              |                          |   |                             |                          |                                      |                              |                          |  |                              |                          |   |                              |                          |  |                              |                          |  |                              |                          |                             |                              |                          |  |  |  |  |                              |                          |        |  |  |  |   |     |    |                             |                          |  |                             |                          |   |                             |                          |   |                             |                          |  |
| 2. <input type="checkbox"/>  | <input type="checkbox"/> | Been advised to undergo surgery within the next six months?                |                              |                          |   |                             |                          |  |                              |                          |                            |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |   |                             |                          |   |                              |                          |                       |                             |                          |                                     |                              |                          |   |                             |                          |   |                              |                          |  |                             |                          |                             |                              |                          |   |                             |                          |                                      |                              |                          |  |                              |                          |   |                              |                          |  |                              |                          |  |                              |                          |                             |                              |                          |  |  |  |  |                              |                          |        |  |  |  |   |     |    |                             |                          |  |                             |                          |   |                             |                          |   |                             |                          |  |
| 3. <input type="checkbox"/>  | <input type="checkbox"/> | Been refused or had health insurance cancelled within last 5 years?        |                              |                          |   |                             |                          |  |                              |                          |                            |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |   |                             |                          |   |                              |                          |                       |                             |                          |                                     |                              |                          |   |                             |                          |   |                              |                          |  |                             |                          |                             |                              |                          |   |                             |                          |                                      |                              |                          |  |                              |                          |   |                              |                          |  |                              |                          |  |                              |                          |                             |                              |                          |  |  |  |  |                              |                          |        |  |  |  |   |     |    |                             |                          |  |                             |                          |   |                             |                          |   |                             |                          |  |
| 4. <input type="checkbox"/>  | <input type="checkbox"/> | Is anyone listed on the application in impaired mental or physical health? |                              |                          |   |                             |                          |  |                              |                          |                            |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |  |                             |                          |  |                              |                          |   |                             |                          |   |                              |                          |                       |                             |                          |                                     |                              |                          |   |                             |                          |   |                              |                          |  |                             |                          |                             |                              |                          |   |                             |                          |                                      |                              |                          |  |                              |                          |   |                              |                          |  |                              |                          |  |                              |                          |                             |                              |                          |  |  |  |  |                              |                          |        |  |  |  |   |     |    |                             |                          |  |                             |                          |   |                             |                          |   |                             |                          |  |

(B) Has any person listed on the application:

1.   Ever been advised to undergo a surgical operation which was not performed?
2.   Been advised to undergo surgery within the next six months?
3.   Been refused or had health insurance cancelled within last 5 years?
4.   Is anyone listed on the application in impaired mental or physical health?

(C) NAME AND COMPLETE ADDRESS OF DOCTOR(S) SEEN BY YOU WITHIN LAST 2 YEARS

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NAME AND COMPLETE ADDRESS OF DOCTOR(S) SEEN BY SPOUSE WITHIN LAST 2 YEARS

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(D) List below full details to questions answered "YES" in Sections A and B, if doctor has been seen in last 2 years, give reason of visit. If additional space is needed, list on a separate sheet of paper and attach to this application.

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

PLEASE READ BEFORE SIGNING;

I hereby apply to Blue Cross and Blue Shield of Georgia, Inc. I understand and agree that if my application is accepted benefits will not be effective until the date shown on the Identification Card of the Subscriber's Contract(s) to be issued to me, which will set forth the benefits to be received and the conditions upon which they will be made available. I understand that benefits of this Plan are not available for conditions which require a waiting period until this contract(s) has been continuously in effect for the required waiting period(s) described in my contract(s).

I agree that any contract which may be issued to me shall be binding only if all statements in this application are complete and true to the best of my knowledge and belief, and, further, that notice to and knowledge of your representative is not notice to or knowledge of Blue Cross and Blue Shield of Georgia, Inc., and that the Plan may declare ineffective this coverage if any statement in this application is not complete and true to the best of my knowledge and belief. I also understand that my application is subject to medical underwriting before acceptance. This contract replaces and supersedes all contracts which may have been issued previously to the Subscriber to whom this contract is issued. I do hereby authorize any doctor or hospital to furnish you any and all medical records pertaining to each person listed on this application. I also certify all information contained herein is true to the best of my knowledge and belief.

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

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_ Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

RETURN FORM TO: P.O. Box 4445, Atlanta, Georgia 30302