



Your Individual Application Kit is enclosed

Here is a checklist to review before you return your Blue Cross Blue Shield of Georgia Individual Enrollment application.

- Print clearly and complete the application in blue or black ink.
- If you make any changes while completing this form (for example, if you cross out something you wrote), be sure to **initial and date** those changes.
- If any **corrections** are needed or if the form is incomplete, the application may have to be returned to you, or we may try to call you, to obtain the necessary information.
- If your application is approved your coverage can start on any day of the month as early as the date you signed your application providing we receive it within 10 days of that date. We will notify you of your actual effective date in writing.
- The primary applicant, spouse/domestic partner and all applicants ages 18 or older, if applicable, must sign and date the application in two places (page 10 and 11).**
- List the height and weight for each applicant.
- List the date of birth for each applicant.
- If you have had creditable health coverage in the past 63 days, please fill out Section H to apply for preexisting condition credit. Creditable Coverage is defined as prior coverage from a major medical plan such as a group plan, Medicaid, health plan for active military personnel, including TRICARE, Federal Employees Health Benefits Program, state children's health insurance program, U.S. Government plans, foreign health plans, or an individual insurance policy. Prior coverage does not count as Creditable Coverage if there was a break of 63 days or more prior to applying for this coverage.
- Select the plan, deductible amount and any applicable riders requested.
- Answer all health history questions in Section I. Failure to do so will delay the processing of your application.
- If you answered "yes" to any of the health history questions, give complete details on page 6.
- For Automatic Bank Draft, complete the Authorization located in Section J.
- The initial premium is required with the application. Please provide your credit card authorization per the instructions in Section J. If you pay by check, please make the check payable to Blue Cross Blue Shield of Georgia, and affix the check to the front of the application. Please note: Your check will not be cashed or your credit card will not be debited until your application has been approved.
- If you are eligible for Medicare, you are not eligible to apply for our individual products.
- Prior to submitting, please make a copy of the signed application for your records.**

Mail or fax completed application to:

**Blue Cross Blue Shield of Georgia
3350 Peachtree Road, NE
Mail Stop GAG008-0005
Atlanta, GA 30326**

OR

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

If you need assistance filling out the application, please contact your agent.



Georgia Individual Enrollment Application



Please complete in blue or black ink only. Do not write in shaded areas, these are for internal use only.

Section A – Coverage Information

Application Type (select one): Change BCBSGa Individual policy coverage Add dependent(s) to current coverage
 New Coverage Policy No. _____ Policy No. _____

Effective date requested: If your application is approved your coverage can start on any day of the month as early as the date you signed your application providing we receive it within 10 days of that date. We will notify you of your actual effective date in writing.

Please choose the date you would like your coverage to start: ____ / ____ / ____ **MM/DD/YYYY**

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

Last Name	First Name	MI	Social Security Number*
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Home Address (street and P.O. Box if applicable)

City	State	Zip	County
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Billing Address (street and P.O. Box if different from above)

City	State	Zip	County
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Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	Height (Ft./In.) /	Weight	Sex M F	Age	Date of Birth / /
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Daytime Phone Number ()	Evening Phone Number ()	E-mail* If possible, do you want E-mail notification? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Language Choice (For statistical purposes only.) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Korean <input type="checkbox"/> Chinese (C/M)
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Section C – Spouse or Domestic Partner Information

Last Name	First Name	MI	Social Security Number*
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Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Height (Ft./In.) /	Weight	Sex M F	Age	Date of Birth / /
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Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Language Choice (Optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Korean <input type="checkbox"/> Chinese (C/M)
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Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary.)

If this is an application for a Family Contract, list all eligible dependents. This includes all unmarried, dependent children, stepchildren, or legally adopted children under age 19 or up to the age of 26 if a full-time student, or as otherwise mandated by state law. List dependents in order of age, beginning with the oldest.

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

Are all dependent children legal residents of the United States and residents of the state in which you are applying for coverage? Yes No

Has any person listed on this application lived (not traveled) outside the U.S. for the past 3 consecutive months? Yes No

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

Section E – Medical Coverage (Select ONE plan, then select ONE deductible and any optional riders.)

BlueChoice® PPO

- Premier \$750 BA \$1,500 BB \$2,500 BC \$5,000 BD \$10,000 BE \$20,000 BF
 Consumer Choice Option **Maternity Rider**
- SmartSense \$750 BG \$1,500 BH \$2,500 B \$5,000 BJ \$10,000 BK \$20,000 BL
 Consumer Choice Option **Buy-up Drug Rider**

Flex Plus

- Flex Plus \$2,500 AA \$5,000 A5 \$10,000 AC

HSA Compatible HDHP PPO

- Single HDHP PPO (80% coinsurance) . . \$1,150 AO \$1,800 AP \$2,600 AQ Consumer Choice Option
 Single HDHP PPO (100% coinsurance) . . \$1,150 AR \$1,800 AS \$2,600 AT Consumer Choice Option
 Family HDHP PPO (80% coinsurance) . . \$2,300 AU \$3,500 AV \$5,150 AW Consumer Choice Option
 Family HDHP PPO (100% coinsurance) . . \$2,300 AX \$3,500 AY \$5,150 AZ Consumer Choice Option

- Yes, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Blue Cross Blue Shield of Georgia (BCBSGa) will provide your information to BCBSGa's banking partner. (Please fill in your social security number in section B.)
- No, I DO NOT want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above.

Section F – Dental Coverage Selection

- BlueChoice® Dental** GAD1 Yes, I wish to add dental coverage (at an extra cost per individual).
 If Yes, select ONE coverage type (applies to individuals listed on this application only):
 Applicant only Applicant & Spouse or Domestic Partner only
 Applicant, Spouse or Domestic Partner, and all dependent children listed
 Applicant & all dependent children listed
- Yes, if myself or any listed family member are declined for medical coverage, still enroll **all members selected above, if eligible.**

Section G – Greater Georgia Life Insurance Company Term Life Insurance

- Yes, in addition to my medical coverage, I wish to apply for Term Life Insurance (at an extra cost per individual).
 Do you, the applicant, own an existing life policy? Yes No
 By applying for this proposed life policy, do you intend to replace, discontinue or change any existing life policy? Yes No
 Provide information below.
 Applicants must meet Blue Cross Blue Shield of Georgia's Underwriting Guidelines to qualify for Term Life Insurance Coverage.
 Applicants under the age of one year are not eligible for Life Insurance. All Term Life policies terminate at age 65.

Applicants	Birthday (mm/dd/yyyy)	Coverage Amount (select one)	Beneficiary**	% Allocation	Relationship	Social Security Number
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$75,000* <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$100,000* <input type="checkbox"/> \$50,000*	Primary: Contingent:			
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$75,000* <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$100,000* <input type="checkbox"/> \$50,000*	Primary: Contingent:			
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$75,000* <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$100,000* <input type="checkbox"/> \$50,000*	Primary: Contingent:			
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$75,000* <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$100,000* <input type="checkbox"/> \$50,000*	Primary: Contingent:			

* Amounts above \$25,000 are not available to applicants under the age of 20. If selected by an approved applicant under age 20, the selection will default to \$25,000.

** If a beneficiary is not listed and a policy is issued, death benefits will be paid in accordance with the Beneficiary Provision of the Policy.

Section H – Other Health Coverage		
Are you or anyone applying for coverage currently eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, give name. _____		
Do you currently have health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did you or your eligible dependents have creditable coverage within the past 63 days? <input type="checkbox"/> YES <input type="checkbox"/> NO (you may be eligible for preexisting credit).		
The following information must be completed in order for credit to be given. Please provide the previous 24 months of coverage.		
Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name and phone number of prior carrier(s)		Reason for cancellation
Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Effective Date of Coverage	Cancellation Date of Coverage
Will you be canceling this coverage if approved for Blue Cross Blue Shield of Georgia coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Complete this section if you've had more than one carrier in the last 24 months (attach a separate sheet if necessary).		
Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name and phone number of prior carrier(s)		Reason for cancellation
Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Effective Date of Coverage	Cancellation Date of Coverage
Will you be canceling this coverage if approved for Blue Cross Blue Shield of Georgia coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Section I – Health History (IMPORTANT: This section has two steps)		

If you have questions about how to complete this application call your agent or Customer Service at 1-800-718-8831.

STEP 1: Health history questions must be answered by each/every person applying for coverage.

Health History Questionnaire — All questions must be answered or the application will be returned.

GIVE COMPLETE DETAILS IN STEP 2 (page 6) FOR ALL QUESTIONS ANSWERED “YES”.

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. We are relying on the information you provide to determine whether you are eligible for coverage. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician(s) to clarify your specific condition. We have the right to review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, do not assume we will review all of your medical records before approving your application. If we issue coverage to you and later discover that you intentionally misrepresented or omitted information you knew in response to a question we may rescind your coverage, even after it has been issued. This means that you may lose your health benefits including coverage for treatment already received. Rescission may occur even if we review your medical records or seek medical confirmation of your health information as part of processing your application. Even if you currently have health insurance coverage or had prior coverage with Blue Cross Blue Shield of Georgia, you must fully disclose and answer all health history questions.

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

Section I – Health History (continued)

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test) or urine test, x-ray(s), CAT scan, MRI, or mammogram? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Step 2) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you pregnant or an expectant father, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have implants, prosthesis or retained hardware? | | |
| A. Breast implants | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Eye/limb prosthesis | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Joint replacement/internal fixations (i.e. pins, plates, rods etc.), neurostimulators | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Any other prosthesis or implant (other than dental) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?
(all answers must be checked yes or no) | | |
| A. Headaches requiring prescription medication | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Loss of consciousness | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Sleep apnea/breathing difficulties while sleeping | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Recurrent fainting, weakness or dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Paralysis or numbness/tingling in limbs | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Chest pain | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Increased/irregular heart beat | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Low or high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| I. High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Heartburn (recurrent) | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Abnormal and/or Recurrent bleeding (unrelated to menstruation) | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Recurrent diarrhea and/or recurrent vomiting | <input type="checkbox"/> | <input type="checkbox"/> |
| N. Unexplained weight loss | <input type="checkbox"/> | <input type="checkbox"/> |
| O. Blood, sugar, and/or protein in urine | <input type="checkbox"/> | <input type="checkbox"/> |
| P. Recurrent pain (including back pain) | <input type="checkbox"/> | <input type="checkbox"/> |
| Q. Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| R. Mass, cyst(s), or lump(s) in any body part including breast | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|--|--------------------------|--------------------------|
| 7. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following? | | |
| A. Abnormal Pap smear | <input type="checkbox"/> | <input type="checkbox"/> |
| B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease) | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Male infertility | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Female fertility/infertility | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart, circulatory or blood disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Kidney, bladder or prostate disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Hernia; hemorrhoid; rectal, or intestinal disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems | <input type="checkbox"/> | <input type="checkbox"/> |
| N. Psoriasis, rosacea, acne or skin disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| O. Cataract, glaucoma, eye or ear disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| P. Diabetes, thyroid, endocrine glands | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Within the last 5 years, have you experienced, suffered from, consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Within the last 5 years, have you been advised by a health care professional to reduce alcohol intake? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Within the last 5 years have you had counseling or treatment for any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in Step 2.) | | |
| A. Obsessive Compulsive Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Minor depression | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Anxiety/panic attacks | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Attention Deficit Disorder (ADD/ADHD) | <input type="checkbox"/> | <input type="checkbox"/> |

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

Section I – Health History (continued)

- | | YES | NO |
|--|--------------------------|--------------------------|
| 12. Within the last 5 years, have you experienced (suffered from) or consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to drug abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. In the past 10 years have you had consultation, been diagnosed, had treatment or treatment recommended for any of the following: | | |
| A. Schizophrenia, Major Depression/ BiPolar Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Eating disorder (i.e. anorexia/bulimia) | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Down's Syndrome | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Autism | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been diagnosed with hepatitis? (check all types that apply) | | |
| A. Hepatitis A | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Hepatitis B | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Hepatitis C, D, E | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever been diagnosed with, or treated for any of the following? | | |
| A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|---|--------------------------|--------------------------|
| B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Diabetes, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma. | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you a candidate for, or have you ever received an organ or bone marrow transplant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18a. Within the last 5 years, have you had any illness, physical injury, persisting or new physical symptoms and/or health problems not mentioned elsewhere on this application that have not been evaluated or that you plan to have evaluated by a licensed health practitioner? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Date last seen by a physician: _____ | | |
| Reason: _____ | | |

Other Health Questions

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1a. Within the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco? (If cigarettes, please check the appropriate box below based on the number of cigarettes smoked per day during the last 12 months.) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-39 | | |
| <input type="checkbox"/> 40-49 <input type="checkbox"/> 50 or more | | |
| 1b. Within the past 12 months, have you stopped using all tobacco products? If yes, how many months ago has it been since you stopped? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 1-3 months | | |
| <input type="checkbox"/> 4-6 months | | |
| <input type="checkbox"/> 7-9 months | | |
| <input type="checkbox"/> 10-12 months | | |

- | | YES | NO |
|---|--------------------------|--------------------------|
| 2. Within the past 12 months, have you consumed alcoholic beverages? (If yes, please check the appropriate box below based on your average weekly consumption of alcoholic beverages during the last 12 months. One beverage equals 12 oz. of beer, 4 oz. of wine, or 1 oz. of liquor.) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 0-7 <input type="checkbox"/> 8-14 <input type="checkbox"/> 15-20 | | |
| <input type="checkbox"/> 21-26 <input type="checkbox"/> 27-35 <input type="checkbox"/> 36 or more | | |
| 3. Within the past 12 months, have you used marijuana? (If yes, please check the appropriate box below.) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> less than 4 times per month | | |
| <input type="checkbox"/> 5 - 7 times per month | | |
| <input type="checkbox"/> 8 or more times per month | | |
| 4. Within the past 5 years, have you used cocaine, heroin, ecstasy, LSD or any other illicit drug(s)? | <input type="checkbox"/> | <input type="checkbox"/> |

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

Section I – Health History *(continued)*

STEP 2: If you answered “YES” to any of the health history questions, give complete details (see the example below)

Question Number of “YES”	Patient First Name	Physician Name & Telephone (with area code)	Specific Diagnosis & Treatment	Name & Dosage of Medication & Dates of Use		Duration of Condition		Was Surgery Performed?		Description of Surgery/ Procedures & Date(s) (mm/yyyy)	Current Status
				Begin (mm/yyyy)	End (mm/yyyy)	Begin (mm/yyyy)	End (mm/yyyy)	YES	NO		
Example: #17	Mary	Dr. John Doe 555-555-1000	Tonsillitis	Amoxicillin 250 mg. 4x day 08/2002 09/2002		08/2002	09/2002	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy 09/2002	Good
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		

Please check box if an additional sheet(s) of paper has been completed for this chart.

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

Section J – Billing Options

INITIAL PREMIUM

Check Enclosed (If paying by check, make the check payable to Blue Cross Blue Shield of Georgia.)

Total amount enclosed/charged: \$

Credit Card (see below)

METHOD (select one)

BILL TO HOME—Bills will be sent to your home billing address unless a separate billing address is listed below.

BILL TO OTHER

Name	Address (street and P.O. Box if applicable)	City	State	Zip

AUTOMATIC BANK DRAFT (automatic premium withdrawals to begin 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 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 Blue Shield of Georgia that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Blue Cross Blue Shield of Georgia and my financial institution have the right to discontinue the withdrawals if they wish to do so.

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

IF PAYING BY CREDIT CARD: A credit card can be used for the initial premium payment only.

Credit card information

Cardholder Name (as shown on the credit card):	Cardholder Address:
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If applicant is using the credit card of another cardholder: By signing this form, 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 this payment and any charges accruing to it.

Type of credit card: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover	Credit Card Number: Expiration Date (month/year):
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Authorization:

*I authorize Blue Cross Blue Shield of Georgia to charge the credit card indicated for the amount specified in **Initial Premium**.*

Applicant signature: X

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

