



Member Enrollment Application (Group size 100+)

Employee Social Security No.

Please print in ink and return to your employer. Use extra sheets if necessary.

BlueChoice Healthcare Plan (HMO), Blue Open Access HMO, BlueChoice Option (POS), Blue Open Access POS, Blue Essential (Hospital/Surgical) Open Access HMO, and Blue Essential (Hospital/Surgical) Open Access POS plans offered by Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP).

BlueChoice PPO, Anthem Lumenos HSA, HRA, HIA and HIA+, Traditional Health Plan, Blue Essential (Hospital/Surgical) PPO, Dental, Vision, and EAP plans offered by Blue Cross and Blue Shield of Georgia, Inc. (BCBSGA).

Life and Disability plans offered by Greater Georgia Life Insurance Company, Inc. (GGL).

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., Blue Cross and Blue Shield of Georgia, Inc., and Greater Georgia Life insurance Company are independent licensees of the Blue Cross and Blue Shield Association. Life and Disability products underwritten by Greater Georgia Life insurance Company. ANTHEM and Lumenos are registered trademarks of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

EMPLOYER/GROUP USE ONLY:	BCBSGA USE ONLY: Lumenos plan information
Group Name _____	Case Number _____
Group Number _____	Group Number _____
Sub-section _____	

Section 1: Tell us about yourself

Date of Hire _____	Effective Date _____	Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA
Reason for Application (Check as many as apply) <input type="checkbox"/> New group initial enrollment <input type="checkbox"/> Annual open enrollment <input type="checkbox"/> New hire		
Last Name _____	First Name _____	MI _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Date of Birth / /
Employee Mailing Address (street and P.O. Box if applicable)		
City _____	State _____	Zip _____ County _____
Home Phone _____	Business Phone _____	

Section 2: Type of coverage you are applying for

Medical Plans	Specialty Plans	Consumer Choice Option <i>Additional premium applies.</i>																																																																																		
<table border="1"> <tr> <th>Plan Selection</th> <th>Plan #</th> </tr> <tr><td><input type="checkbox"/> HMO*</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Open Access HMO</td><td>_____</td></tr> <tr><td><input type="checkbox"/> POS*</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Open Access POS</td><td>_____</td></tr> <tr><td><input type="checkbox"/> PPO</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Anthem® Lumenos® PPO (HSA)</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Anthem Lumenos PPO (HRA)</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Anthem Lumenos PPO (HIA Plus)</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Anthem Lumenos PPO (HIA)</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Traditional (Indemnity)</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Blue Essential (Hospital/Surgical)</td><td>_____</td></tr> <tr> <td><input type="checkbox"/> I refuse coverage (Please sign and date on page 4)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> I have other coverage</td> <td></td> </tr> <tr> <td><input type="checkbox"/> I have coverage through my spouse</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Another Reason</td> <td></td> </tr> </table>	Plan Selection	Plan #	<input type="checkbox"/> HMO*	_____	<input type="checkbox"/> Open Access HMO	_____	<input type="checkbox"/> POS*	_____	<input type="checkbox"/> Open Access POS	_____	<input type="checkbox"/> PPO	_____	<input type="checkbox"/> Anthem® Lumenos® PPO (HSA)	_____	<input type="checkbox"/> Anthem Lumenos PPO (HRA)	_____	<input type="checkbox"/> Anthem Lumenos PPO (HIA Plus)	_____	<input type="checkbox"/> Anthem Lumenos PPO (HIA)	_____	<input type="checkbox"/> Traditional (Indemnity)	_____	<input type="checkbox"/> Blue Essential (Hospital/Surgical)	_____	<input type="checkbox"/> I refuse coverage (Please sign and date on page 4)		<input type="checkbox"/> I have other coverage		<input type="checkbox"/> I have coverage through my spouse		<input type="checkbox"/> Another Reason		<table border="1"> <tr> <th>Plan Selection</th> <th>Plan #</th> </tr> <tr><td><input type="checkbox"/> Dental</td><td>_____</td></tr> <tr><td><input type="checkbox"/> I refuse coverage</td><td></td></tr> <tr><td><input type="checkbox"/> Vision</td><td>_____</td></tr> <tr><td><input type="checkbox"/> I refuse coverage</td><td></td></tr> <tr><td><input type="checkbox"/> Life</td><td>_____</td></tr> <tr><td><input type="checkbox"/> I refuse coverage</td><td></td></tr> <tr><td><input type="checkbox"/> Short Term Disability</td><td>_____</td></tr> <tr><td><input type="checkbox"/> I refuse coverage</td><td></td></tr> <tr><td><input type="checkbox"/> Long Term Disability</td><td>_____</td></tr> <tr><td><input type="checkbox"/> I refuse coverage</td><td></td></tr> <tr> <td colspan="2" style="text-align: center;">If you refused coverage for any Specialty Plan listed, please sign and date on page 4.</td> </tr> </table>	Plan Selection	Plan #	<input type="checkbox"/> Dental	_____	<input type="checkbox"/> I refuse coverage		<input type="checkbox"/> Vision	_____	<input type="checkbox"/> I refuse coverage		<input type="checkbox"/> Life	_____	<input type="checkbox"/> I refuse coverage		<input type="checkbox"/> Short Term Disability	_____	<input type="checkbox"/> I refuse coverage		<input type="checkbox"/> Long Term Disability	_____	<input type="checkbox"/> I refuse coverage		If you refused coverage for any Specialty Plan listed, please sign and date on page 4.		<table border="1"> <tr> <td colspan="2">Do you want the Consumer Choice Option version of this plan? 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*HMO and POS plans must select a PCP for each enrolled member.	If you selected an HMO or POS plan above, please complete the following. <input type="checkbox"/> I am an existing patient Primary Care Physician (PCP) Name: _____ PCP ID#: _____
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Employee Social Security No. _____

Section 3: Do you have other insurance?

After coverage begins, will you or any dependents have any other medical insurance including Medicare? Yes No

Policy Holder Name	Insurance Company Name	Insurance Effective Date / /
Insurance Policy Number	Policy Holder Date of Birth / /	
Insurance Company Address	Who is covered? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Family	
Are you eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your spouse eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Part A/Effective Date / /	<input type="checkbox"/> Part A/Effective Date / /	
<input type="checkbox"/> Part B/Effective Date / / <input type="checkbox"/> Part D/Effective Date / /	<input type="checkbox"/> Part B/Effective Date / / <input type="checkbox"/> Part D/Effective Date / /	
Medicare HIC #	Is Medicare coverage related to end stage renal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 4: Tell us about your family (If electing Employee only coverage, skip to Section 5)

Complete the following information on your family members who are applying for coverage. *HMO/POS plans only: Please select a primary care physician in the space provided.*

Spouse:

Sex	Last Name	First	M.I.	Social Security Number	Birthdate	PCP Name	PCP ID No.	Existing Patient
<input type="checkbox"/> M <input type="checkbox"/> F					/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you applying for: Medical Dental Life Vision (check all that apply) Are you Handicapped/Disabled? Yes No

Are the dependent children the biological children of either the applicant, spouse or both?
 Yes No If no, please complete a Certification of Dependency form. You can download one from www.bcbgsa.com Members>Member Services>Download Forms

Child #1:

Are you applying for: Medical Dental Life Vision (check all that apply)
 Are you handicapped/disabled: Yes No College student? Yes No If yes:
 Date first attended college _____ Name of college _____ State _____ Anticipated Graduation Date _____

Sex	Last Name	First	M.I.	Social Security Number	Birthdate	PCP Name	PCP ID No.	Existing Patient
<input type="checkbox"/> M <input type="checkbox"/> F					/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No

Child #2:

Are you applying for: Medical Dental Life Vision (check all that apply)
 Are you handicapped/disabled: Yes No College student? Yes No If yes:
 Date first attended college _____ Name of college _____ State _____ Anticipated Graduation Date _____

Sex	Last Name	First	M.I.	Social Security Number	Birthdate	PCP Name	PCP ID No.	Existing Patient
<input type="checkbox"/> M <input type="checkbox"/> F					/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No

Child #3:

Are you applying for: Medical Dental Life Vision (check all that apply)
 Are you handicapped/disabled: Yes No College student? Yes No If yes:
 Date first attended college _____ Name of college _____ State _____ Anticipated Graduation Date _____

Sex	Last Name	First	M.I.	Social Security Number	Birthdate	PCP Name	PCP ID No.	Existing Patient
<input type="checkbox"/> M <input type="checkbox"/> F					/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have additional dependents, please attach a separate sheet.

Section 5: Life Insurance - Complete this section if you are applying for Life coverage through Greater Georgia Life Insurance, Inc.

Employee Job Title	Salary Earnings (if applicable) \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual <input type="checkbox"/> Other
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Type of Coverage Applied for:
 Basic Life/AD&D \$ _____ Dep. Life Spouse Yes No Supplement Life/AD&D \$ _____ Dep. Life Child Yes No
 STD \$ _____ LTD Monthly \$ _____

Primary Beneficiary Name (Required)	Relationship	Contingent Beneficiary Name	Relationship
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WAITING PERIODS FOR APPLICANTS OF:

- POS
- Open Access POS
- Blue Essential (Hospital/Surgical) POS
- PPO
- Anthem Lumenos
- Blue Essential (Hospital/Surgical) PPO
- Traditional Health Plan

POS, Open Access POS, Blue Essential (Hospital/Surgical) POS: During such a waiting period, no pre-existing conditions will be covered on your out-of-network benefits for the next 12 months.

Anthem Lumenos, PPO, Blue Essential (Hospital/Surgical) PPO, Traditional Health Plan: During such a waiting period, no pre-existing conditions will be covered on your in- or out-of-network benefits for the next 12 months (exception: pregnancy).

If a waiting period is imposed and you disagree with the decision, please ask your employer for more information regarding previous coverage certification or call customer care at 1-800-441-2273. You may appeal the waiting period and provide additional evidence of prior coverage within 30-days of receiving written notification that a waiting period has in fact been imposed. Providers are compensated using a variety of payment arrangements, including fee-for-service, per diem, discounted fees, and global reimbursement.

Upon reviewing your application, we will review it and any certificates of prior coverage. Based on the information you submit, a waiting period for pre-existing condition(s) may apply to your coverage.

A pre-existing condition is any illness, injury or other condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the previous six months prior to your effective date in this Plan.

CONFIDENTIALITY IS OUR PRIORITY

We are committed to maintaining the confidentiality of our members' protected health information (PHI). PHI of any kind, including information about member medical care or health status, is protected by our confidentiality policies and procedures.

All confidential PHI is treated with care and protected against unauthorized disclosure. We preserve the confidentiality of our members' personal and medical information in accordance with current statutory, regulatory and accreditation requirements.

Data shared with employer groups cannot be implicitly or explicitly member-identifiable, unless specific member authorization has been obtained. These policies address confidentiality in many areas of our business, including:

- Our routine use and disclosure of PHI
- Use of authorizations
- Access to PHI
- Internal protection of oral, written and electronic PHI
- Protection of information disclosed to Plan sponsors for employees
- The member's right to authorize or deny the release of PHI beyond treatment, payment or health care operations
- Use of our Web site as a means to communicate our confidentiality practices
- Information included in member's routine and special consent
- Access and release of medical records
- Protection of privacy in all settings
- Use of measurement data
- Building security
- Electronic claims handling
- Employee responsibility
- Corporate integrity

HOW WE MAINTAIN YOUR PRIVACY AND DATA SECURITY:

- All associates sign a statement ensuring that any information learned about a member will be held in confidence. These forms are required to be signed upon employment and annually thereafter.
- Access to information is controlled and limited to personnel who have an appropriate and approved need.
- Confidential information obtained for the purpose of ensuring, measuring and improving quality is housed in a specific department within the organization, with limited access to this information.
- Data shared with employer groups is not member-identifiable, unless member consent is provided.
- All contracted providers, vendors and/or delegated entities agree to our confidentiality policies and procedures by submitting a written certification to us, which contains strict confidentiality clauses.
- Except when such release is required by law, members may consent to, or refuse, the release of medical or other identifiable information by us.
- Except as permitted by law, member information is not released unless the member, or their authorized representative, provides either routine or special consent.

RIGHTS AND OBLIGATIONS

Employee Social Security No. _____

I hereby apply for (a) the medical coverage specified in the Contract between my Employer and Blue Cross and Blue Shield of Georgia, Inc. and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., (hereinafter referred to as the Company) and (b) if so indicated, life insurance provided by the Group Insurance Contract issued by Greater Georgia Life Insurance Co. to my Employer for myself and my eligible family members.

I understand and agree that the effective date of coverage will be governed by the stipulations of the Group Application and the Master Group Contract under which this application is made. I understand that membership will continue according to the terms of the contract between my Employer and the Company. I hereby authorize my Employer to periodically deduct any charge due from me here under and to remit same to the Company along with any contribution due from Employer. I understand and agree that the Company reserves the right to change the subscription charges due for this coverage and to increase or decrease the benefits by giving sixty (60) days written notice to my Employer.

I hereby authorize any hospital, physician, psychiatrist, psychologist, counselor, psychiatric hospital or other provider, dispenser of prescription drugs, appliances, ambulance service or any person or any institution rendering services to me or members of my family if covered hereunder, to furnish to the Company and/or Greater Georgia Life Insurance Co. all requested information concerning treatment, advice, psychiatric care or medical care for previous or future conditions, illnesses or disabilities.

I declare that all statements made hereon including the information provided in this application are complete and true to the best of my knowledge and belief, and agree that the Company may cancel this coverage within two (2) years from the effective date, for any ineligible family member or one on whom erroneous or intentionally false information has been submitted, personally assuming liability for reimbursement to the Company for any benefit payment made on behalf of such family member. After this contract has been in force for a period of two (2) years during the lifetime of the insured, it shall become incontestable as to the statements in the applications. I understand that I am responsible for giving notice to my Employer of any changes in my status and that of family members which affect coverage.

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.

The following information is requested for statistical purposes including the compilation of data indicating the incidence of specific disease, condition or treatment patterns. It is not required to process your application and you may

decline to answer if you prefer. Please select the category that best describes your ethnic background.

- American Indian / Alaskan Native
- Black / African American
- Mexican/Mexican American
- Asian/Asian-American, or Pacific Islander
- Puerto Rican
- Other Hispanic or Latin
- White (non-Hispanic)
- Other _____
- Primary Language _____
- Secondary Language _____

PLEASE READ THE CONFIDENTIALITY AND PRIVACY INFORMATION ON PAGE 4 BEFORE SIGNING THIS APPLICATION. IF YOU ARE APPLYING FOR COVERAGE AND PORTABILITY RULES APPLY, PLEASE FURNISH PROOF OF YOUR PRIOR COVERAGE WITH APPLICATION.

CERTIFICATION AND SIGNATURE

Do you have prior coverage? Yes No

If yes, and portability rules apply, please furnish proof of your prior coverage with this application.

I declare that all statements and information made hereon are complete and true to the best of my knowledge. I understand that any intentional misstatements or omissions may void all coverage applied for on any member, including myself and all dependents, on this application on a retroactive basis for up to two (2) years from the contract effective date.

By signing this line, I understand that a pre-existing condition exclusion may apply (except for HMO, Open Access HMO, and in-network POS, Open Access POS and Blue Essential (Hospital/Surgical) POS) up to twelve (12) months under the Company contract, as defined in the benefit booklet.

I hereby acknowledge that the Company 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 the Company.

Employee Signature
X

Date

Group Administrators, please mail applications to:

Blue Cross and Blue Shield of Georgia
P.O. Box 4445
Atlanta, GA 30302

or Fax to (888) 470-6598.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

Employee Social Security No. _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in the group's Certificate Booklet, which you may obtain from your employer.) In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the Plan based on a health status-related factor.

Complete if you are declining coverage for yourself or any dependent:

If you are declining coverage for yourself or for any of your eligible dependents, you must complete the following information if you want to preserve your rights of special enrollment as explained above. If you decline coverage for yourself, the reason is:

- I have other coverage Spousal group coverage Another reason

If you decline coverage for one or more eligible dependents, give the dependent's name below and indicate the reason coverage is declined.

Name _____ Dependent has other coverage Another reason

Name _____ Dependent has other coverage Another reason

Name _____ Dependent has other coverage Another reason

Name _____ Dependent has other coverage Another reason

Employee Name - Please Print

Employee Social Security Number

Employee Signature

_____/_____/_____
Date

Please return this form to your company's Group Administrator.

