Member Enrollment Change Form

PRINT CLEARLY USING BLACK INK ONLY

Employee social security no.

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).

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EMPLOYER/GROUP USE ONLY

Group name	Group no.	Subsection

ANTHEM USE ONLY: LUMENOS PLAN INFORMATION

Case no.	Group no.

Last name	First name	M.I	Effective date of changes below

ADDRESS CHANGE

Employee mailing address (street and PO box if applicable)

City	State	ZIP code	County

NAME CHANGE

Last name	First name	M.I

Sex	Birthday
☐ Male ☐ Female	

TYPE OF COVERAGE CHANGE

	Plan no.	Consumer Choice (Additional premium applies)
☐ HMO*		☐ Yes ☐ No
☐ Open Access HMO		☐ Yes ☐ No
☐ Traditional Health		☐ Yes ☐ No
☐ Traditional (Indemity)		☐ Yes ☐ No
☐ Blue Essential (Hospital/Surgical)		☐ Yes ☐ No
☐ PPO		☐ Yes ☐ No
☐ Anthem Lumenos PPO HSA Qualfied		☐ Yes ☐ No
☐ Anthem Lumenos PPO (HRA)		☐ Yes ☐ No
☐ Anthem Lumenos PPO (HIA)		☐ Yes ☐ No
☐ Anthem Lumenos PPO (HIA+)		☐ Yes ☐ No

	Plan no.	Consumer Choice (Additional premium applies)
☐ POS*		☐ Yes ☐ No
☐ Open Access POS		☐ Yes ☐ No
☐ Anthem Lumenos Open Access POS (HSA)		☐ Yes ☐ No
☐ Anthem Lumenos Open Access POS (HRA)		☐ Yes ☐ No
☐ Anthem Lumenos Open Access POS (HIA)		☐ Yes ☐ No
☐ Anthem Lumenos Open Access POS (HIA+)		☐ Yes ☐ No
Dental		
Vision		
Life [GGL]		
STD		
LTD		
EAP		

*If changing coverage to an HMO or POS plan, you must select a primary care physician (PCP) for each covered dependent in the spaces provided below.

PCP name	Physician I.D. no.	Are you applying for Dental Insurance? ☐ Yes ☐ No	I am an existing patient ☐ Yes ☐ No

TRANSFER TO ANOTHER GROUP NUMBER

Group no.	Sub	Lumenos case no.	Lumenos group no.	Coverage transfer effective date

Employee social security no.

LIFE INSURANCE – COMPLETE THIS SECTION IF YOU ARE APPLYING FOR LIFE COVERAGE THROUGH GREATER GEORGIA LIFE INSURANCE, INC.

Employee job title	Salary earning (if applicable) $_____ ☐ Weekly ☐ Monthly ☐ Annual ☐ Other
Type of coverage applied for:	☐ Basic Life/AD&D $ _____ ☐ Supplemental Life/AD&D $ _____ Dependent life spouse ☐ Yes ☐ No Dependent life child ☐ Yes ☐ No ☐ STD $ _____ ☐ LTD monthly $ _____

Primary beneficiary name (required)	Relationship	Contingent beneficary name	Relationship

ADD DEPENDENTS PLEASE CHECK REASON FOR ADDITION AND FILL IN APPROPRIATE SPOUSE AND/OR CHILDREN INFORMATION BELOW

☐ Adoption ☐ Birth ☐ COBRA ☐ Courts ☐ Loss of Coverage
☐ Marriage ☐ Open Enrollment ☐ Other (please explain): _____

Effective date of change

SPOUSE

Last name	First name	M.I	Social security no.

Sex	Birthdate	Existing patient	PCP name	PCP I.D. no.
☐ Male ☐ Female		☐ Yes ☐ No		

Are you applying for (check all that apply): ☐ Medical ☐ Dental ☐ Life ☐ Vision 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.bcbsga.com.

CHILD 1

Last name	First name	M.I	Social security no.

Sex	Birthdate	Existing patient	PCP name	PCP I.D. no.
☐ Male ☐ Female		☐ Yes ☐ No		

Are you applying for (check all that apply):	Are you Handicapped/Disabled?	College student?
☐ Medical ☐ Dental ☐ Life ☐ Vision	☐ Yes ☐ No	☐ Yes ☐ No If yes, fill out below boxes

Name of college	State	Date first attended college	Anticipated graduation date

CHILD 2

Last name	First name	M.I	Social security no.

Sex	Birthdate	Existing patient	PCP name	PCP I.D. no.
☐ Male ☐ Female		☐ Yes ☐ No		

Are you applying for (check all that apply):	Are you Handicapped/Disabled?	College student?
☐ Medical ☐ Dental ☐ Life ☐ Vision	☐ Yes ☐ No	☐ Yes ☐ No If yes, fill out below boxes

Name of college	State	Date first attended college	Anticipated graduation date

CHILD 3

Last name	First name	M.I	Social security no.

Sex	Birthdate	Existing patient	PCP name	PCP I.D. no.
☐ Male ☐ Female		☐ Yes ☐ No		

Are you applying for (check all that apply):	Are you Handicapped/Disabled?	College student?
☐ Medical ☐ Dental ☐ Life ☐ Vision	☐ Yes ☐ No	☐ Yes ☐ No If yes, fill out below boxes

Name of college	State	Date first attended college	Anticipated graduation date

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

Employee social security no.

RIGHTS AND OBLIGATIONS

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, PO Box 105370, Atlanta, GA 30348-5370.

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 _____

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, Blue Essential (Hospital/Surgical) 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 Date

Group administrators, please mail applications to: Blue Cross Blue Shield of Georgia
PO Box 4445
Atlanta, GA 30302

OR **Fax: 888-470-6598**

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