Georgia Short-Term Enrollment Application

1. Please complete all pages of this application. 2. Print in blue or black ink.
3. Send completed application and payment to: **Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.**
Mail Stop GAG008-0005 · 3350 Peachtree Road, NE · Atlanta, GA 30326

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

Last Name	First Name	MI	Social Security Number*

Home Street Address (Must be completed: P.O. Box not acceptable)

City	State	ZIP	County

Mailing Address (If different from above) or P.O. Box

City	State	ZIP	County

Marital Status
☐ Single ☐ Married ☐ Domestic Partner

Are you a legal resident of the United States and a resident of the state of Georgia? ☐ Yes ☐ No

Evening Phone Number	Daytime Phone Number	E-mail Address*
( )	( )	If possible, do you want E-mail notification? ☐ Yes ☐ No

Section B – Plan Selections

Deductible (Individual):
☐ $250 ☐ $1,000
☐ $500 ☐ $2,500

Policy Term (Number of Days):
_____ (minimum of 30 up to a maximum of 180 days)

Optional Coverage:
☐ Consumer Choice Option

Section C – Effective Date

If your application is approved your coverage can start on any day of the month after the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.

Please choose the date you would like your coverage to start: _____/_____/_____ (MM/DD/YYYY)

Section D – Applicants for Coverage

- Please list ALL applicants applying for coverage (including applicant listed in Section A). If a family member's last name is different than yours, please explain on a separate page.
- Newborn children under 30 days of age are not eligible for coverage.
- Dependents between the ages of 19 to age 26 if a full-time student are eligible for coverage, or as otherwise mandated by state law.
- BCBSHP will enroll all eligible family members unless otherwise instructed below.

☐ I, the Applicant, request that Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. not enroll any eligible applicants unless ALL family members qualify.

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

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

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

Section E – Health History (Answer the following questions completely and accurately.)

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

	YES	NO
1. Is any applicant currently pregnant (includes positive pregnancy test within the last 30 days), an expectant father, or in the process of adoption or surrogate pregnancy?	☐	☐
If YES, who? _____		
2. Within the last **TEN** years, has any applicant been diagnosed with or treated for AIDS or ARC?	☐	☐
If YES, provide the name of each person: _____		
3. Within the last **FIVE** years, has any applicant been advised by a healthcare provider to have testing, examination, evaluation, treatment, therapy, or surgery that has not yet been completed?	☐	☐
If YES, who? _____		
4. Within the last **FIVE** years, has any applicant been a candidate for or been a recipient of an organ or bone marrow transplant?	☐	☐
If YES, provide the name of each person: _____		
5. Within the last **30 DAYS**, has any applicant been admitted to an inpatient hospital or surgical facility?	☐	☐
If YES, who? _____		
Specify condition(s): _____		
6. Within the last **12 MONTHS**, has any applicant received a prescription or taken any prescribed medication except for birth control for contraception, hormone replacement therapy, Synthroid, or short term (10 days or less) antibiotics?	☐	☐
If YES, provide the name of each person: _____		
Specify medication(s) and condition(s): _____		
7. Within the last **FIVE** years, has any applicant been diagnosed with or received treatment for heart, lung, blood (e.g. Hemophilia, leukemia), blood vessel, kidney, liver, brain, nerve or immune system disorders, diabetes, cancer, stroke, heart attack, high blood pressure, ulcerative colitis, Crohn's Disease, or alcohol abuse or drug abuse?	☐	☐
If YES, who? _____		
Specify condition(s): _____		

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Section F – Significant Terms, Conditions and Authorizations (TERMS)

It is important that you carefully read and fully understand the following before signing the application.

By applying for coverage, I, the undersigned, agree to the following:

1. I understand that it is mandatory that I notify Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP), in writing, immediately if I (the applicant) or any other person for whom coverage is sought received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date or the date underwriting approves, whichever is later. I understand that in this situation, BCBSHP has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be rescinded, or delayed, or reformed or benefits denied due to the illness, injury or condition being treated as a preexisting condition.

2. Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP) may decline my application. No coverage comes into effect until BCBSHP approves this application and informs me in writing.

3. Cashing my check does not mean my application is approved. If this application is declined, neither BCBSHP nor any affiliated company shall have any liability to me or any one else listed on it, except for the obligation to return the money submitted with this application.

4. No agent has the authority to bind coverage or waive the answer to any question in this application, to pass insurability, to waive any of BCBSHP's rights or requirements or to make or alter any contract.

5. Any of my dependents listed on this application who are over the age of 18 years have read this application and have provided complete and accurate information for this application. Also, I have done everything necessary to be able to assure you that all information about any children under the age of 18 listed on this application is true and complete to the best of my knowledge and belief. I understand and agree that I alone am responsible for the accuracy and completeness of this application. I understand and agree that no one listed on this application will be eligible for coverage if any information is false or incomplete and that BCBSHP may revoke coverage if it discovers that any information on this application is incomplete or false.

6. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)

7. I understand BCBSHP may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.

8. I acknowledge that I have read, or have had read to me, the completed application. I realize that if I omit any information or provide any fraudulent or, intentionally misleading or incomplete information that is considered fraud or material misrepresentation, this can result in claim denial and/or cancellation of this coverage. I agree to repay promptly any benefit payment to which my dependents or I was not entitled. I understand that the contract applied for will not provide benefits for any expenses incurred on account of any condition that manifested itself before the contract effective date, as explained in the "Exclusions " section of my contract. I also understand that this is not a continuation of any previous medical program, including any prior Short Term Medical contract.

9. I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 6 months or more; he or she is mentally competent; he or she, is at least 18 years old; is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.

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Section F – Significant Terms, Conditions and Authorizations (TERMS) (continued)

I, the undersigned, hereby apply for the coverage indicated for my eligible family members and myself. I understand and agree that coverage will not be effective, nor will Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP) have any liability, unless and until this application is accepted and approved by Medical Underwriting, and a contract issued with identification cards showing effective dates. I understand that BCBSHP may require a physical examination of anyone listed on this application. BCBSHP reserves the right to change any applicable premiums for new coverage issued after the expiration date of this policy. I declare that all statements made hereon are complete and true to the best of my knowledge and belief, and agree that BCBSHP may cancel the coverage in its entirety or for any covered individual, if fraudulent or intentionally misleading information has been submitted, personally assuming liability for reimbursement to BCBSHP for any benefit payment made on behalf of any such family member. Ineligible persons may be removed at any time.

I authorize BCBSHP, or an agent, subsidiary or affiliate that has a business associate contract with BCBSHP, to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations. I also authorize any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans, medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations to furnish any medical records or health history information concerning me and any family member listed on my Application to BCBSHP, or an agent, subsidiary or affiliate that has a business associate contract with BCBSHP.

IF LISTED ON YOUR APPLICATION, YOUR SPOUSE/DOMESTIC PARTNER AND EACH DEPENDENT CHILD OVER AGE 18 MUST SIGN BELOW.

Signature of Applicant/Parent or Legal Guardian **X**	Date
Signature of Spouse or Domestic Partner **X**	Date
Signature of Dependent age 18 or over **X**	Date
Signature of Dependent age 18 or over **X**	Date
Signature of Dependent age 18 or over **X**	Date

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Section G – Agent Certification

To be completed by your BCBSHP Appointed Agent.

1. Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting? . . . . . ☐ Yes ☐ No

2. Did you see the applicant (and spouse/domestic partner, if applying) at the time this application was executed? . . . . . ☐ Yes ☐ No

   If NO, please explain: _____

3. Total funds collected: . . . . . $ _____

4. **I certify to the best of my knowledge and belief, the responses herein are accurate.**

Agent Signature (required) **X**			Date (required)
Agent Name (please print)	Agent Street Address / Suite No. / Personal Mail Box (PMB) No.		
Agent ID No.	City/State/ZIP	County Code	Area
Agent Phone No.	Agent Fax No.	Agent Email Address	

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Conditional Receipt

THIS RECEIPT DOES NOT PROVIDE ANY COVERAGE UNTIL ALL THE TERMS AND CONDITIONS LISTED BELOW ARE MET.

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP) has received from the named Applicant an advance deposit equal to at least the first 30 days of premium together with an application for designated health insurance coverage. Such payment is accepted subject to the following conditions:

- Subject to the provisions of the contract, the coverage applied for will be effective from, and the contract date as of, the day following acceptance by Medical Underwriting, unless otherwise specifically stated, provided that the payment evidenced by this receipt is at least the first 30 days of premium and provided that BCBSHP determines that as of the date of the application all proposed covered persons were acceptable for coverage and for the benefits applied for.
- If the application is not approved by BCBSHP said Plan shall incur no liability and the payment evidenced by this receipt will be refunded to the applicant.
- No one has the authority to waiver or modify any of the terms or conditions of this receipt.

If you do not receive a contract within 30 days, please contact Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Customer Service at (855)402-9635 or Post Office Box 105370, Atlanta, Georgia 30348-5370.

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 need your answers to decide if you qualify for coverage. 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. Official Code of Georgia, code 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 Blue Shield Healthcare Plan of Georgia, Inc. Customer Service at (855)402-9635 or Post Office Box 105370, Atlanta, Georgia 30348-5370.

Submitting Your Application

- **Please mail this application to:** **Blue Cross Blue Shield**
  Healthcare Plan of Georgia, Inc.
  Mail Stop GAG008-0005
  3350 Peachtree Road, NE
  Atlanta, GA 30326

  OR **Fax to: (866)538-0824 Toll Free**
- For information on eligibility, please call BCBSHP Customer Service (855)402-9635.
- Save time by applying online (if paying by credit card) at **www.bcbsga.com**.

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Payment Methods for Individual Short Term Coverage Georgia

Applicant / Member Name:	Primary Applicant's Social Security Number:

Premium must be paid in full and submitted with application and will be held in trust while this application is evaluated.

Step 1: Calculate your Total Premium

$_____ X _____ = $_____

Amount of premium (per day rate) | # of days | Total Premium

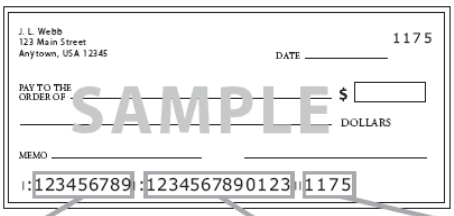
Step 2: PLEASE TELL US HOW YOU WILL PAY YOUR FULL PREMIUM

☐ Check / Money Order attached (make payable to Blue Cross and Blue Shield of Georgia)*

*When you provide a check as payment, you authorize us to either use the information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic fund transfer, funds will be withdrawn from your account as soon as the day of approval and you will not receive your check back from your financial institution. **I understand that a service charge may be incurred for any withdrawal not honored.**

☐ Electronic Check (complete Section A) ☐ Credit / Debit Card (complete Section B)

A. Payment by Electronic Check. By providing your check information below, you authorize Blue Cross and Blue Shield of Georgia to electronically debit your bank account. If you are approved for coverage, your bank account will be debited for the total premium amount in step 1. **I understand that the premium amount may vary as a result of change(s) during the underwriting process. I also understand that a service charge may be incurred for any withdrawal not honored.** Please void this check to prevent future use.



With this payment option, there is no need to send a paper check with your application.

If paying by electronic check, please complete the boxes to the right

Bank Routing No.	Bank Account No.	Check No.

Authorized Signature (as it appears on the financial institution's records) X_____	Account Holder Name	Date

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

B. Payment by Credit/Debit Card - As a convenience to me, I request and authorize Blue Cross and Blue Shield of Georgia to charge the credit/debit card indicated one time for the initial premium payment amount upon approval. I understand that if this option is selected, my account will be debited the total premium payment for the specified term of coverage as soon as the day of approval. **If the initial premium payment amount varies from the quote generated by the system or due to changes during the underwriting process, I also authorize Blue Cross and Blue Shield of Georgia to charge the credit/debit card indicated for the different amount.**

I agree that Blue Cross and Blue Shield of Georgia is fully protected in honoring any credit/debit card payments. I further agree that if any credit/debit card payment is dishonored, with or without cause, intentionally or inadvertently, Blue Cross Blue Shield of Georgia is under no liability whatsoever, including any fees imposed by credit/debit card company or my bank, if my credit/debit card is rejected even though such dishonor results in termination of coverage. **I also understand that a service charge may be incurred for any withdrawal not honored**. **We accept Visa and MasterCard.**

Type of Card: ☐ **Visa** ☐ **MasterCard**

Card Number:	Expiration Date:		
Authorized Signature (as it appears on the credit/debit card) **X**_____	Cardholder Name (as it appears on the credit/debit card)		Date
Cardholder Billing Address	City	State	Zip

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

PPO medical, dental, and vision products are offered by Blue Cross and Blue Shield of Georgia, Inc. (BCBSGa). HMO and POS products are offered by Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP). Life and disability products are underwritten by Greater Georgia Life Insurance Company (GGL), using the trade name Anthem Life. BCBSGa, BCBSHP and GGL are independent licensees of the Blue Cross and Blue Shield Association. ®ANTHEM is a registered trademark 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.