



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

**NOTE: If the answer to any question from 1-3 is YES, the policy cannot be issued for that applicant. Answering NO to questions 1-3 does not guarantee coverage. All answers will be validated and a brief review of claims history may be completed.**

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|--|--------------------------|--------------------------|
|  | <b>YES</b>               | <b>NO</b>                |
| 1. a) Is any applicant pregnant, or in the process of adoption or surrogate pregnancy? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Is any applicant listed on this application an expectant parent, the child of an expectant parent, or in the process of adoption or surrogate pregnancy with anyone, whether or not the mother is listed on this application? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If YES, applicant(s) to whom question 1 applies:</b> _____  |                          |                          |
| 2. Within the past 5 years, have you or any person listed on this application received any medical or surgical consultation, advice or treatment, including medication for:  |                          |                          |
| a) heart or circulatory system disorder including heart attack or chest pain; stroke? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b) disorders of the blood, including hemophilia and leukemia; diabetes; cancer or tumor? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| c) alcoholism or alcohol abuse; drug abuse or chemical dependency? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| d) immune disorders; organ transplant; kidney or liver disorders? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If YES, applicant(s) to whom question 2 applies:</b> _____  |                          |                          |
| 3. Has any person listed on this application been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If YES, applicant(s) to whom question 3 applies:</b> _____  |                          |                          |

**Section F – Payment and Billing Options**

<p>▶ <b>Please enter the monthly premium amount, number of months you would like coverage, and calculate the total premium below:</b></p> <p>_____ X _____ = _____</p> <p>Monthly Premium Amount      No. of Months      Total Policy Premium</p>	<p>▶ <b>Please select your premium payment frequency:</b></p> <p><input type="checkbox"/> Monthly    <input type="checkbox"/> Total Policy Premium</p>
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▶ **You may make your initial premium payment by sending a paper check with your application or by completing the credit card section below. If you have chosen monthly premium payments, they can be made by automatic bank draft or credit card; paper billing is not an option for this contract. Complete the appropriate sections below.**

**AUTOMATIC BANK DRAFT** (automatic premium withdrawals to begin in the 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 and 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 and Blue Shield of Georgia that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand that Blue Cross and 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)	Name of Bank	Account Number
Account Holder Signature (if other than applicant) <b>X</b>	Routing Number	Account Holder's SSN

**CREDIT CARD:**     **Initial Premium**     **Monthly Premium**     **Initial and Monthly Premiums**

**Credit card information** (Your monthly premium will be charged to the account on or about the 5th of each month.)

Cardholder Name (as shown on the credit card)	Cardholder Address:
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*If the applicant is using the credit card of another cardholder: By signing this form, the 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 the payments 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 (mm/yyyy):
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**Authorization:**  
*I authorize Blue Cross and Blue Shield of Georgia to charge the credit card indicated for the amount of the specified premium.*

Applicant signature: <b>X</b>
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**Section G – 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. Blue Cross and Blue Shield of Georgia (BCBSGA) may decline my application. No coverage comes into effect until BCBSGA approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be indicated on the identification card and/or assigned by BCBSGA at its discretion.
2. I may request an effective date as early as the date I signed my application (provided we receive it within 10 days of that date) or as late as 75 days from the signature date. If I do not request an effective date, the date my application is approved will be used. Coverage will begin at 12:01 AM ET on the effective date.
3. Cashing my check does not mean my application is approved. If this application is declined, neither BCBSGA 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 BCBSGA'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 BCBSGA 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 BCBSGA 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.

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 and Blue Shield of Georgia (BCBSGA) 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 BCBSGA may require a physical examination of anyone listed on this application. BCBSGA 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 BCBSGA 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 BCBSGA for any benefit payment made on behalf of any such family member. Ineligible persons may be removed at any time.

**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 <b>X</b>	Date
Signature of Spouse or Domestic Partner <b>X</b>	Date
Signature of Dependent age 18 or over <b>X</b>	Date
Signature of Dependent age 18 or over <b>X</b>	Date
Signature of Dependent age 18 or over <b>X</b>	Date

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

## Section H – Agent Certification

### To be completed by your BCBSGA 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) <b>X</b>			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		

### CONDITIONAL RECEIPT

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

Blue Cross and Blue Shield of Georgia (BCBSGA) has received from the named Applicant an advance deposit equal to at least the first month's 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 the full first month's premium and provided that BCBSGA 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 BCBSGA 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 and Blue Shield of Georgia Customer Service at (800)718-8831 or Post Office Box 7368, Columbus, Georgia 31908-7368.

### 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 and Blue Shield of Georgia Customer Service at (800)718-8831 or Post Office Box 7368, Columbus, Georgia 31908-7368.

### SUBMITTING YOUR APPLICATION

- Please mail this application to: **Blue Cross and Blue Shield of Georgia** OR Fax to: **(404) 682-3237**  
**Mail Stop GAG008-0005** **(866) 538-0824 Toll Free**  
**3350 Peachtree Road, NE**  
**Atlanta, GA 30326**
- For information on eligibility, please call BCBSGA Customer Service (800)718-8831.
- Save time by applying online (if paying by credit card) at **www.bcbsga.com**.