Individual Term Life Insurance Application

If you are a BCBSGA member, enter your BCBSGA member ID no.

FOR HOME OFFICE USE ONLY

Greater Georgia Life Insurance Company

SECTION 1: APPLICANT INFORMATION

Applicant name (last, first, MI)				Social security no.
Residential address	City	State	ZIP code	County
Home phone no.	Daytime phone no.	Fax no.	Email address	

SECTION 2: MEDICAL QUESTIONS – Complete the following for all persons to be covered

All questions must be answered with respect to each person for whom you are applying for coverage. Indicate if anyone listed on this application has EVER had medical advice, treatment, OR if you know of the following health problems: (Questions answered "Yes" must be explained in detail in the space provided. If additional space is needed, list on a separate sheet of paper and attach to this application.)

1. Cardiovascular disease or heart attack; stroke; high blood pressure ☐ Yes ☐ No
2. Disorder of the kidneys, bladder, stomach, intestines, or liver ☐ Yes ☐ No
3. Musculoskeletal, mental or nervous conditions, central nervous system disorders ☐ Yes ☐ No
4. Diabetes, emphysema, bronchitis or any chest, lung or respiratory problem or disorder ☐ Yes ☐ No
5. Cancer or acquired immune deficiency disorder (AIDS), or AIDS-related complex, not including the results of HIV testing ☐ Yes ☐ No
6. Are you pregnant? ☐ Yes ☐ No
7. What is your height?
   Applicant _____ Feet _____ Inches Spouse _____ Feet _____ Inches
8. What is your weight?
   Applicant _____ Feet _____ Inches Spouse _____ Feet _____ Inches

SECTION 3: TERM LIFE INSURANCE – Coverage selection and beneficiary

By applying for this proposed life policy(ies), do you, the applicant intend to replace, discontinue or change any existing life policy? ☐ Yes ☐ No
If you answered "yes" to the above question, fill out the attached life replacement insurance notice along with the application.
Applicants under the age of one year are not eligible. All term life policies terminate at age 65.

Family member	Birthdate (MM/DD/YYYY)	Height	Weight	Amount of benefit (see note below)	Beneficiary name	Beneficiary social security no.	Relationship
				☐ $15,000 ☐ $75,000 ☐ $25,000 ☐ $100,000 ☐ $50,000	Primary: _____		
					Contingent: _____		
				☐ $15,000 ☐ $75,000 ☐ $25,000 ☐ $100,000 ☐ $50,000	Primary: _____		
					Contingent: _____		
				☐ $15,000 ☐ $75,000 ☐ $25,000 ☐ $100,000 ☐ $50,000	Primary: _____		
					Contingent: _____		
				☐ $15,000 ☐ $75,000 ☐ $25,000 ☐ $100,000 ☐ $50,000	Primary: _____		
					Contingent: _____		

Note: Amounts above $25,000 are not available to applicants under the age of 20. If selected by an approved applicant under the age of 20, the selection will default to $25,000. If a beneficiary is not listed and the Policy is issued, death benefits will be paid according to the Beneficiary Provision in the Policy.

Life and disability products are offered by Anthem Life. Anthem Life is the trade name of Greater Georgia Life Insurance Company (GGL).

null null

SECTION 4: NOTICE OF EXCHANGE OF INFORMATION

To proposed Insured and other persons proposed to be Insured, if any – information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Reporting Act. The address of MIB's information office is: PO Box 105, Essex Station, Boston, Massachusetts 02122; and telephone number is 866-692-6901 (TTY: 866-346-3642 for hearing impaired).

SECTION 5: AUTHORIZATION AND ACKNOWLEDGEMENT – Read carefully before signing

I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB Group, Inc., to Greater Georgia Life Insurance Company (GGL), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of GGL. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. GGL will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that GGL may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that GGL collects about me, and that I may receive a more detailed description of my rights under this law by writing to GGL.

I understand that GGL reserves the right to accept or decline this application and that no right whatsoever is created by this application.

I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage. I also acknowledge receipt and understanding of the Notice of Exchange of Information explained above. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates.

Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s). This authorization, for purposes of processing this application form, is valid from the date signed for a period of thirty months unless revoked by me in writing, which I may do at any time by contacting GGL. A photocopy is as valid as the original.

I give this authorization for and on behalf of myself and my eligible dependents, including my children and my spouse (if spouse does not sign below), if covered by the Plan. I am acting as their agent and representative.

Signature of applicant **X**	State of residence	Date
Signature of spouse **X**	State of residence	Date
Signature of other family Member age 18 or older **X**	State of residence	Date

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FOR SALES AGENT USE ONLY

Does the applicant intend to replace, discontinue or change any existing life policy? ☐ Yes ☐ No
If yes, advise applicant against replacing before application is approved, and sign the following replacement notice.

Rep no.	Monthly premium	Amount received

Agent name null null	Fax no.
Agent signature **X**	Email address

null null

Life Insurance Replacement Notice

Greater Georgia Life Insurance Company
PO Box 4445
Atlanta, GA 30302

Replacing your life insurance policy?

Are you thinking about buying a new policy and discontinuing or changing an existing policy? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy.

Make sure you understand the facts. Georgia law gives you the right to obtain a policy summary statement from your existing insurer at any time. Ask the company or agent that sold you your existing policy to give you information about it.

Below is a check list of some of the items you should consider in making your decision. TAKE TIME TO READ IT.

Do not let one agent or insurer prevent you from obtaining information from another agent or insurer which may be to your advantage.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

☐ If you wish a policy summary statement from your existing insurer, or insurers, check this box.

We are required to notify your existing company that you may be replacing their policy.

List each existing policy or contract you are contemplating replacing. If a policy number has not been assigned, use an alternative identification such as an application or a receipt number.

Insurer name	Policy no.	Name of insured

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

Applicant signature	Date	Agent signature (if applicable)	Date
X		**X**	

Items to consider

1. If the policy coverages are basically similar, premiums for a new policy may be higher because rates increase as your age increases.
2. Cash values and dividends, if any, may grow slower under a new policy initially because of the initial costs of issuing a policy.
3. Your present insurance company may be able to make a change on term that may be more favorable than if you replace existing insurance with new insurance.
4. If you borrow against an existing policy to pay premiums on a new policy, death benefit payable under your existing policy will be reduced by the amount of any unpaid loan, including unpaid interest.
5. Current interest rates are not guaranteed. Guaranteed interest rates are usually considerable lower than current rates. What rates are guaranteed?
6. Are premiums guaranteed or subject to change – up or down?
7. Participating policies pay dividends that may materially reduce the cost of insurance over the life of the contract. Dividends, however, are not guaranteed.

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