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BlueCross BlueShield of Georgia

Life's next big adventure is just around the corner.

Let us help you get there safely.

Short Term Medical Coverage

We want you to live every single moment to the fullest. And that means being prepared for whatever life has in store. So while you're waiting for life's next chapter to begin, let's make sure you have the protection needed to carry you through to your next journey.

Now, you can get the short term coverage you need to meet life's crossroads

When you have Short Term Medical coverage with Blue Cross and Blue Shield of Georgia, (BCBSGA) you're making the best choice possible to cover your health needs. Why would you need short term coverage? This could be for any of the following reasons:

- You're between jobs
- You're waiting for permanent coverage from us for an Individual or Family plan
- You have a waiting period for coverage at a new job
- You're a temporary or seasonal employee
- You're a dependent who is no longer covered by your parent's plan

With a Short Term Medical PPO policy from BCBSGA, you'll get the coverage Georgians have known and trusted for over seventy years.

You're covered almost immediately

Once we receive your properly completed application (one that includes the correct initial and subsequent payment information) we will begin processing it immediately. See the attached application form to determine when your policy can be effective.

Here's what your plan includes:

- Coinsurance: Once your deductible is met, we pay 80 percent of the eligible charges when you visit a PPO provider. And, once your out-of-pocket maximum is met, we're responsible for 100 percent of any additional eligible charges. If you use an out-of-network provider for anything except a medical emergency, your portion of the payment is 40 percent.
- Choice of Deductible - You have options of $250, $500, $1,000 and $2,500
- A lifetime maximum benefit of $2,000,000.
- An extension of benefits for total disability.
- Prescription Drug Coverage – For generics you pay a $15 copayment or 40 percent coinsurance whichever is greater, no matter which pharmacy you visit. For Brand-name drugs, you pay a $15 copayment or 40 percent, whichever is greater after a separate $250 deductible.
- Out of Pocket Limit: After you pay your deductible you will pay no more than $3,000 (or $6,000 for two or more covered persons) in coinsurance or copayments , as long as you stay within our network. After that, BCBSGA Short Term plan pays 100 percent of covered benefits.

Your BCBSGA Short Term coverage plan is a PPO. Here's how it works.

PPO stands for Preferred Provider Organization. A PPO uses a network of providers (hospitals, doctors, and other medical providers) that have agreed to accept our negotiated rates as payment for their services. With BCBSGA's PPO, you have the freedom to see any provider you choose. That means you can visit providers outside our network and still have benefits.

Using network and non-network providers — what's the difference?

Choosing providers within our network can save you money

With a BCBSGA PPO plan, you have access to our large network of providers. Because these providers have agreed to a lower charge, any coinsurance you owe is significantly reduced. And if you haven't met your deductible yet, with a network provider you're only responsible for paying our negotiated rate — so you save money even before your benefits begin. However, if you choose to see a provider who is not in our network, your costs can be significantly higher.

You can find the network of preferred medical providers by going to bcbsga.com and clicking on "Find a Doctor."

Covered services you can count on, from day one

Short Term services can definitely have long term benefits. Your Short Term PPO has many of the benefits of a regular long-term policy that could make a healthy difference in the long run. Take a look at the services you'll receive:

Outpatient Hospital Care

- Emergency care for injuries
- Medical emergencies
- Pre-admission testing
- Surgery
- Diagnostic services
- Certain therapy services

Inpatient Hospital Care

- Semi-private room/board and intensive care
- Operating and recovery rooms/supplies
- Prescribed drugs, injections and solutions
- Miscellaneous services/supplies
- Diagnostic services

Physician Care

- Inpatient medical care
- Physician office visits
- Preventive care for adults/children
- Surgical services
- Surgical assistant (inpatient only)
- Anesthesia services
- Consultation services
- Diagnostic services
- Certain therapy services

Other Providers of Care

- Home health agency (up to 40 visits)
- Ambulatory surgical center
- Skilled nursing facility (up to 30 days)

Other Services/Supplies

- Prescription drugs
- Prosthetic appliances

Flexible plan options for uncertain timeframes

When you apply, you decide how long you want your coverage to last; from one month to six months, in one month increments. You can pay the entire premium up front, or monthly. And, when your coverage ends, if you decide you need additional coverage you can reapply for a second policy with a term of up to six months. However, if you have two consecutive policies, you must wait one year before you can apply for a third Short Term Medical policy.

If you choose more than one month of coverage on your application, then you'll be required to select a subsequent payment option. Just tell us how you plan to make the additional payments on your application and your application will be complete. If this information is not included, your start date could be delayed.

More good news!

If your application for permanent Individual or Family coverage with us is approved while you have our Short Term Medical coverage, then all of your unused Short Term Medical premium will be applied to your permanent policy.

Ready to Enroll?

Contact your BCBSGA sales representative today.

This brochure should not be mistaken for your Contract. You'll receive a disclosure of all benefits, exclusions and limitations in your contract after your application is approved.

Applying is easy. Follow these simple steps to make sure your application is processed properly:

1. Complete the entire application.
2. Include a check or your credit card information for the initial one month of coverage.
3. If you select more than one month of coverage, let us know how the additional payments will be made (either by an electronic funds transfer (EFT) from your checking account or a charge to your credit card.) Be sure you include the credit card information on your application.
4. Contact your BCBSGA sales representative with any questions.

Take a Free Look

The Georgia Department of Insurance law gives you the first 10 days of coverage to use to change your mind. If you decide to cancel during these 10 days, we will refund your full premium.

To determine your monthly premium amount

- Find the table for the policy type you need (Single, Couple, etc.)
- Use the age of the oldest adult to be covered
- Find your desired deductible to get your rate.

Single

Age	$250	$500	$1,000	$2,500
0-19	143.56	96.82	78.77	57.12
20-24	147.55	99.50	80.95	58.71
25-29	134.42	90.65	73.75	53.48
30-34	146.22	98.61	80.22	58.18
35-39	179.86	121.29	98.68	71.56
40-44	202.73	136.72	111.23	80.66
45-49	245.52	165.57	134.70	97.69
50-54	337.29	227.46	185.06	134.20
55-59	447.21	301.59	245.37	177.94
60-64	704.24	474.93	386.38	280.21

Single & Child

Age	$250	$500	$1,000	$2,500
0-19	287.13	193.63	157.53	114.24
20-24	291.11	196.32	159.72	115.83
25-29	277.98	187.46	152.51	110.60
30-34	289.78	195.42	158.99	115.30
35-39	323.42	218.11	177.45	128.69
40-44	346.29	233.53	189.99	137.79
45-49	389.08	262.39	213.47	154.81
50-54	480.85	324.28	263.82	191.33
55-59	590.78	398.41	324.13	235.06
60-64	847.80	571.74	465.15	337.33

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Single & Children

Age	$250	$500	$1,000	$2,500
0-19	430.69	290.45	236.30	171.37
20-24	434.67	293.13	238.48	172.95
25-29	448.84	302.69	246.26	178.59
30-34	479.23	323.18	262.93	190.68
35-39	529.99	357.41	290.78	210.88
40-44	563.92	380.30	309.40	224.38
45-49	593.43	400.20	325.59	236.12
50-54	679.90	458.51	373.03	270.52
55-59	771.23	520.10	423.14	306.86
60-64	991.37	668.56	543.92	394.45

Couple

Age	$250	$500	$1,000	$2,500
0-19	287.13	193.63	157.53	114.24
20-24	294.80	198.81	161.74	117.30
25-29	268.83	181.29	147.49	106.96
30-34	288.31	194.43	158.18	114.71
35-39	345.26	232.84	189.43	137.37
40-44	390.70	263.48	214.36	155.46
45-49	463.15	312.34	254.11	184.28
50-54	612.61	413.13	336.11	243.75
55-59	805.46	543.18	441.92	320.48
60-64	1,222.42	824.38	670.69	486.39

Family

Age	$250	$500	$1,000	$2,500
0-19	492.51	332.14	270.22	195.96
20-24	500.18	337.31	274.43	199.02
25-29	515.38	347.56	282.77	205.06
30-34	579.27	390.65	317.82	230.48
35-39	666.76	449.65	365.82	265.30
40-44	712.80	480.70	391.08	283.61
45-49	761.64	513.63	417.87	303.05
50-54	870.23	586.87	477.45	346.25
55-59	1,035.48	698.31	568.12	412.01
60-64	1,429.73	964.18	784.42	568.87

Who is eligible?

To be eligible, an applicant must be a Georgia resident, be at least 30 days old, not older than age 64 and not eligible for Medicare.

Please keep in mind the following:

There isn't continuous coverage between policies so your new policy won't provide benefits for any condition or symptom that began during a previous policy or during the five years before the effective date of coverage. No benefits are available for any period where you aren't covered by our Short Term Medical policy.

If you want an additional policy, you'll need to complete a new application. If approved, we'll send you a new policy. Please be aware that if you receive two consecutive policies, you must wait one year before you can apply for a third.

Check the following medical criteria that may affect your coverage

With our Short Term Medical coverage, you won't receive coverage for any illness, injury or other condition where medical advice, diagnosis, care or treatment was recommended or received during the last 24 months before the effective date of coverage. In addition, you must meet certain medical requirements in order for us to give you the coverage you desire.

Need help understanding policy terms? Here are some definitions

Copayment: A copayment is a specified amount of money you pay at the time you receive health care services (we pay the remainder). A copayment is similar to coinsurance, except coinsurance is usually a percentage of certain charges while a copayment is a fixed dollar amount.

Coinsurance: This is the amount you'll pay after the cost of medical care once your deductible is paid. It's usually expressed as a percentage of the fees incurred.

Deductible: This is the amount you would pay before your health care plan pays for covered services. The deductible is usually a set amount. For example, a health care plan might require you to pay the first $500 during a calendar year before the health care plan begins paying for covered services.

Premium: This is the periodic cost of your insurance policy.

Total disability: This is a condition that is the direct result from a disease or injury. As a result, you aren't able to perform the major duties of your job and you can't work for wages or profit.

Exclusions

As with all health plans, there are some exclusions. Your contract does not provide benefits for: the 12 months following the effective date of the policy for any illness, injury or other condition for which medical advice, diagnosis, care or treatment was recommended or received 24 months prior to the effective date; services and supplies not medically necessary or not consistent with the diagnosis; treatment for which payment is made by any local, state or federal government (except Medicaid); services paid under Medicare or the Veterans Administration; any injury or disease related to war, declared or undeclared, or military service; convalescent or custodial care; hair transplants, eyeglasses/contact lenses/ radial keratotomy and the examinations associated with them; hearing aids; experimental services; weight reduction or treatment for obesity; physical, occupational or speech therapy for developmental delay; infertility or cosmetic services, except as otherwise stated in the contract.

In addition, pregnancy related services are not covered. Also not covered are dental care and treatment and oral surgery. A full disclosure of all benefits, exclusions and limitations is included in the Contract for this coverage or any optional coverage amendments. Please review these carefully upon enrollment.

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Blue Cross and Blue Shield of Georgia
3350 Peachtree Road, N.E.
Atlanta, GA 30326

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MGABR3348G Rev. 2/09

Georgia Short-Term PPO 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 and Blue Shield of Georgia · 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/Family):
☐ $250/$500 ☐ $1,000/$2,000
☐ $500/$1,000 ☐ $2,500/$5,000

Policy Term (Number of Months):
☐ 1 month ☐ 3 months ☐ 5 months
☐ 2 months ☐ 4 months ☐ 6 months

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.
- BCBSGA will enroll all eligible family members unless otherwise instructed below.

☐ I, the Applicant, request that Blue Cross and Blue Shield 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 and Blue Shield of Georgia.

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): _____		

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

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 and Blue Shield of Georgia (BCBSGA), 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, BCBSGA 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 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.

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.

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.

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

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 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.

I authorize BCBSGA, or an agent, subsidiary or affiliate that has a business associate contract with BCBSGA, 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 BCBSGA, or an agent, subsidiary or affiliate that has a business associate contract with BCBSGA.

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

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

Section G – 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) **X**			Date (required)
Agent Name (please print) null null	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	

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

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**
  Mail Stop GAG008-0005
  3350 Peachtree Road, NE
  Atlanta, GA 30326
  OR
  Fax to: (404) 682-3237
  (866) 538-0824 Toll Free
- 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**.

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

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Payment Methods for Individual Short Term Health Coverage Georgia

BlueCross BlueShield of Georgia

BlueCross BlueShield Healthcare Plan of Georgia

Please complete in blue or black ink.

Applicant Name:	Primary Applicant's Social Security Number:

Monthly premium amount: $_____ Full premium amount: $_____

☐ **I want to pay the full premium now.**

PLEASE TELL US HOW YOU WILL PAY YOUR FULL PREMIUM:

☐ Credit/Debit Card (complete Section B)

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

☐ **I understand the first month's premium is required with my application and want to pay future premiums on a monthly basis.**

PLEASE TELL US HOW YOU WILL PAY YOUR FIRST PREMIUM:

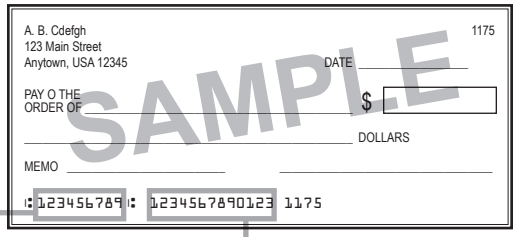
☐ Credit/Debit Card (complete Section B)

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

NOTE: FUTURE PREMIUMS MUST BE PAID THROUGH AUTOMATIC BANK PAYMENT (PLEASE COMPLETE SECTION A).

* When you provide a check as payment, you authorize us either to use 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.

A. Automatic Bank Payment –
If you have selected this option for your initial payment, your bank account may be debited the applicable month's premium as soon as the day of approval. I hereby authorize Blue Cross and Blue Shield of Georgia to initiate a withdrawal between the 1st and 5th business day of each month from the bank account named below.



Provide your Bank Account Information here:

☐ Checking Account

☐ Savings Account **(account number will be different than that of checking account)**. Check with your financial institution to be sure automatic recurring deductions are allowed against this account.

Provide your Bank Account Information here:

9-Digit Bank Routing Number	Bank Account Number
|___|___|___|___|___|___|___|___|___|	

I authorize Blue Cross and Blue Shield of Georgia to initiate premium deductions (and corrections to premium deductions) from the bank account indicated and the designated financial institution to debit the same account. **I understand that the initial premium amount may vary as a result of change(s) during the underwriting process**. I understand that Blue Cross and Blue Shield of Georgia's rights with each premium deduction are the same as if I submit a check signed by me. This authorization is in effect until I provide Blue Cross and Blue Shield of Georgia thirty (30) days written notice that I no longer desire this service, and Blue Cross and Blue Shield of Georgia and the designated financial institution have the right to discontinue the premium deductions if they wish to do so. **I also understand that a service charge may be incurred for any withdrawal not honored.**

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

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

B. 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, the credit/debit card indicated may be charged for the initial premium payment amount as early as the date 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 Anthem 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 and 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. **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 – Please PRINT)		Date
Cardholder Billing Address	City	State	ZIP

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

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