



# INDIVIDUAL MARKETS HEALTH INSURANCE APPLICATION



For Internal Use	DCN
List Bill	

PLEASE PRINT CLEARLY • USE BLACK INK ONLY

LAST NAME	FIRST	MI	SOCIAL SECURITY NO.
DATE OF BIRTH	AGE	HEIGHT	WEIGHT
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	REQUESTED EFFECTIVE DATE	COUNTY	
MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			

**TYPE COVERAGE APPLIED FOR**

**TYPE CONTRACT**  Individual (No Maternity)  Family

BlueChoice Preferred Provider

Consumer BlueChoice Preferred Provider

\$ \_\_\_ Office Visit (\$20 or Deduct.)

\$ \_\_\_ Deductible (\$250, \$500, \$1000, \$1500, \$2500, \$5000)

80 % In-Network of \$10,000

60 % Out of Network

High Deductible

PPO Saver 2000

FlexPlus

\$ \_\_\_ Deductible

Coinsurance 80% of \$ \_\_\_

Hospital - Surgical

\$ \_\_\_ Calendar Year Deductible

Coinsurance 80% of \$ \_\_\_

**FlexPlus and BlueChoice Only**

Do you desire additional nervous and mental coverage (at additional cost)?

YES  NO

**Dental** (at additional cost)

YES  NO

APPLICANT STREET ADDRESS

CITY

STATE

ZIP CODE

HOME PHONE

DAYTIME PHONE NO.

Do you now or will you have any other medical coverage? (check one)  YES  NO

Insurance Co. Name: \_\_\_\_\_ Insurance Eff. Date: \_\_\_\_-\_\_\_\_-\_\_\_\_

Policyholder Name: \_\_\_\_\_

Policy No.: \_\_\_\_\_ Insurance Co. Address: \_\_\_\_\_

Policyholder Date of Birth: \_\_\_\_-\_\_\_\_-\_\_\_\_

Who is covered  Self  Spouse  Family

**After coverage begins, will you or any dependents have any other insurance including Medicare/Medicaid? (check one)  YES  NO**

Are you eligible for Medicare  Part A / Effective Date \_\_\_\_-\_\_\_\_-\_\_\_\_  Part B / Effective \_\_\_\_-\_\_\_\_-\_\_\_\_

Is your spouse eligible for Medicare  Part A / Effective Date \_\_\_\_-\_\_\_\_-\_\_\_\_  Part B / Effective \_\_\_\_-\_\_\_\_-\_\_\_\_

MEDICARE HIC # \_\_\_\_\_

Is Medicare coverage related to end stage renal disease?  YES  NO

Has anyone listed on this application ever been covered by Blue Cross and Blue Shield of Georgia or Blue Cross Blue Shield Healthcare Plan of Georgia?

YES  NO If yes, under what member # \_\_\_\_\_ . Dates From \_\_\_\_\_ to \_\_\_\_\_

Is your home inside the city limits?  YES  NO Have you applied for AD&D coverage?  YES  NO

**If this is an application for a Family Contract, list all eligible dependents. This includes spouse and all unmarried, dependent children, stepchildren, or legally adopted children under age 19 or as otherwise mandated by state law.**

S P O U S E	LAST NAME	FIRST	MI	DATE OF BIRTH
	SOCIAL SECURITY NO.	HEIGHT	WEIGHT	
C H I L D	LAST NAME	FIRST	MI	DATE OF BIRTH
	SOCIAL SECURITY NO.	HEIGHT	WEIGHT	NAME OF COLLEGE
	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	COLLEGE STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	HANDICAPPED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	DATE FIRST ATTENDED COLLEGE	ANTICIPATED GRADUATION DATE		

Are you or your spouse the biological parent of the child/children listed above?  Yes  No \*

\* NOTE: if not a biological parent, complete CERTIFICATE OF DEPENDENCY form.

4607-0293-2306

## Medical Information

**HEALTH QUESTIONS:** All of the following questions must be answered with respect to each person for whom you are applying for coverage. (A) Has anyone listed on this application **EVER** had medical advice, treatment or do you know or have reasons to know of health problems in regard to the following? CHECK YES or NO.

Questions answered "yes" must be explained below in section D. List physician information in section C below.

**(A) Yes No**

1.   Impairment of Sight, Speech or Hearing
2.   Eyes, Ears, Nose, Throat, Head or Brain Disorder
3.   Disease of Endocrine System, Thyroid, Goiter or Diabetes
4.   Asthma, Sinus, Nasal, Allergies or Lung Disorder
5.   High or Low Blood Pressure, Heart Trouble or Vascular Disease
6.   Spine Condition or Bodily Deformity
7.   Disease of Bones or Joints, Arthritis or Rheumatism
8.   Ulcers or Stomach Disorders
9.   Kidney, Bladder or Prostate Disorder
10.   Gallbladder, Liver Disorder, or Hepatitis
11.   Menstrual Disturbances or other Female Disorders
12.   Hemorrhoids, Intestinal or Rectal Disorder
13.   Hernia

**Yes No**

14.   Nervous or Mental Disorder
15.   Fainting Attacks, Convulsions, or Epilepsy
16.   Substance Abuse, Drug or Alcohol Abuse
17.   Blood Disorder, Anemia, Leukemia, or Hemophilia
18.   Tumor, Cyst or Cancer
19.   Is anyone listed on this application currently pregnant?
20.   Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Kaposi Sarcoma, Pneumocystis Carinii Pneumonia, or Antibodies to Human T-Lymphotropic Virus Type III (HTLV-III)
21.   Sexually transmitted diseases such as syphilis, gonorrhea, herpes, genital warts
22.   Any other Medical or Surgical advice or treatments, hospitalizations, or chronic or recurring minor ailments.
23.   Do you now or have you ever, or anyone you are applying for, ever used tobacco products?

**(B) Has any person listed on the application:**

1.   Ever been advised to undergo a surgical operation which was not performed?
2.   Been advised to undergo surgery within the next six months?
3.   Been refused or had health insurance cancelled?
4.   Ever had medical advice, treatment or any known indications of health problems not mentioned in the questions above?

I HAVE ANSWERED ALL QUESTIONS CORRECTLY FOR EVERY PERSON LISTED ON THE APPLICATION

Applicant's Signature \_\_\_\_\_

**(C) NAME AND COMPLETE ADDRESS OF DOCTOR(S) SEEN BY YOU WITHIN LAST 2 YEARS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**NAME AND COMPLETE ADDRESS OF DOCTOR(S) SEEN BY YOU WITHIN LAST 2 YEARS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**List below full details to questions answered "YES" in Sections A and B, if doctor has been seen in last 2 years, give reason of visit. If additional space is needed, list on a separate sheet of paper and attach to this application.**

(D) Health Question Letter	Person Treated	Name of Illness or Disorder	Type of Treatment Received	Treatment Dates		Name and Address of Attending Physician
				From	To	

**Sales Representative Use Only**

Rep. No.	County Code	Area	Deductible	Mthly Fee	Amt Received	Agent Signature
						Print Name: _____
						Fax No.: _____

IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE SHEET.

I, the undersigned, hereby apply for the coverage indicated for myself and my eligible family members. 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, 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, and BCBSGA reserves the right to change the premium charges due for this coverage by giving sixty (60) days written notice to the subscriber. 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 BCBSGA 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 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 false or erroneous 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. After this contract has been in force for a period of two years during the lifetime of the insured, it shall become incontestable as to the misstatements in the application. I understand and agree that this contract, when issued, will replace and supersede all similar contracts which may have been issued previously by BCBSGA or any of its affiliates. **No agent has the authority to waive the answer to any question in this application, to pass on insurability, to waive any of BCBSGA's rights or requirements or to make or alter any contract.**

**Check the appropriate box: I will not receive any benefits for any illness, injury or other condition for which medical advice, diagnosis, care or treatment was recommended or received within the previous twelve (12) months preceding the effective date of coverage under a FLEXPLUS or BlueChoice PPO Contract, or 24 months under a Hospital/Surgical Contract until I have had continuous coverage for 12 months under a FLEXPLUS or BlueChoice PPO Contract, or 24 months under a Hospital/Surgical Contract.**

I DO UNDERSTAND

I DO NOT UNDERSTAND

**PLEASE READ REVERSE SIDE BEFORE SIGNING FOR CONDITIONAL RECEIPT AND PRIVACY INFORMATION.**

I hereby acknowledge that Blue Cross and Blue Shield of Georgia/Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSGA/BCBSHP) (as applicable) 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 of choices of participation/network health care providers
- c. disclosure of contractual relationship between participation/network provider and BCBSGA/BCBSHP

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If family policy)

Daytime Telephone No. \_\_\_\_\_

Daytime Telephone No. \_\_\_\_\_

**CONDITIONAL RECEIPT**

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

**DO NOT MAKE CHECKS PAYABLE TO THE AGENT  
OR LEAVE PAYEE BLANK**

Blue Cross and Blue Shield of Georgia (BCBSGA) has received from the named Applicant an advance deposit equal to the first month's dues 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 dues 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 60 days, please contact Blue Cross and Blue Shield of Georgia Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO  
BLUE CROSS AND BLUE SHIELD OF GEORGIA**

**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. We are required by law to keep such data confidential. It will be seen only by employees and authorized agents. This data may in certain circumstances be disclosed without your authorization. We may furnish such data to authorized federal or state agencies, consumer investigative service bureaus or others if part of our standard business practice or required by law.

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 Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

If my application to become a member of Blue Cross and Blue Shield of Georgia as selected on the front of this application is not accepted, I wish to apply for coverage under the following Direct Pay Insurance Policy:

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Plan 250/250 | <input type="checkbox"/> Hospital / Surgical | <input type="checkbox"/> Plan 250/1000 |
|                                       | <input type="checkbox"/> Plan 250/500        |  |

**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 ✓ the category that best describes your ethnic background.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> American Indian / Alaskan Native           | <input type="checkbox"/> Black / African American | <input type="checkbox"/> Mexican, Mexican American |
| <input type="checkbox"/> Asian, Asian-American, or Pacific Islander | <input type="checkbox"/> Puerto Rican             | <input type="checkbox"/> Other Hispanic or Latin   |
|   |   | <input type="checkbox"/> White (non-Hispanic)      |

Other

Primary Language

Secondary Language

