



Member Enrollment Change Form

PRINT CLEARLY USING BLACK INK ONLY

Employee social security no.									

BlueChoice Healthcare Plan (HMO), Blue Open Access HMO, BlueChoice Option (POS), Blue Open Access POS, Blue Essential (Hospital/Surgical) Open Access HMO, and Blue Essential (Hospital/Surgical) Open Access POS plans offered by Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP).

BlueChoice PPO, Anthem Lumenos HSA, HRA, HIA and HIA+, Traditional Health Plan, Blue Essential (Hospital/Surgical) PPO, Dental, Vision, and EAP plans offered by Blue Cross and Blue Shield of Georgia, Inc. (BCBSGA).

Life and Disability plans offered by Greater Georgia Life Insurance Company, Inc. (GGL).

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EMPLOYER/GROUP USE ONLY

Group name	Group no.	Subsection
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ANTHEM USE ONLY: LUMENOS PLAN INFORMATION

Case no.	Group no.
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Last name	First name	M.I.	Effective date of changes below
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ADDRESS CHANGE

Employee mailing address (street and P.O. box if applicable)

City	State	ZIP code	County
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NAME CHANGE

Last name	First name	M.I.
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Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthday
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TYPE OF COVERAGE CHANGE

	Plan no.	Consumer Choice (Additional premium applies)		Plan no.	Consumer Choice (Additional premium applies)
<input type="checkbox"/> HMO*	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> POS*	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Open Access HMO	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open Access POS	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Traditional Health	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anthem Lumenos Open Access POS (HSA)	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Traditional (Indemnity)	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anthem Lumenos Open Access POS (HRA)	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Blue Essential (Hospital/Surgical)	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anthem Lumenos Open Access POS (HIA)	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> PPO	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anthem Lumenos Open Access POS (HIA+)	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Anthem Lumenos PPO HSA Qualified	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental	_____	
<input type="checkbox"/> Anthem Lumenos PPO (HRA)	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision	_____	
<input type="checkbox"/> Anthem Lumenos PPO (HIA)	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Life [GGL]	_____	
<input type="checkbox"/> Anthem Lumenos PPO (HIA+)	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	STD	_____	
			LTD	_____	
			EAP	_____	

*If changing coverage to an HMO or POS plan, you must select a primary care physician (PCP) for each covered dependent in the spaces provided below.

PCP name	Physician I.D. no.	Are you applying for Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	I am an existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No
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TRANSFER TO ANOTHER GROUP NUMBER

Group no.	Sub	Lumenos case no.	Lumenos group no.	Coverage transfer effective date
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LIFE INSURANCE - COMPLETE THIS SECTION IF YOU ARE APPLYING FOR LIFE COVERAGE THROUGH GREATER GEORGIA LIFE INSURANCE, INC.

Employee job title	Salary earning (if applicable) \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual <input type="checkbox"/> Other
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Type of coverage applied for:	<input type="checkbox"/> Basic Life/AD&D \$ _____ <input type="checkbox"/> Supplemental Life/AD&D \$ _____
	Dependent life spouse <input type="checkbox"/> Yes <input type="checkbox"/> No Dependent life child <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> STD \$ _____ <input type="checkbox"/> LTD monthly \$ _____

Primary beneficiary name (required)	Relationship	Contingent beneficiary name	Relationship
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ADD DEPENDENTS PLEASE CHECK REASON FOR ADDITION AND FILL IN APPROPRIATE SPOUSE AND/OR CHILDREN INFORMATION BELOW

<input type="checkbox"/> Adoption	<input type="checkbox"/> Birth	<input type="checkbox"/> COBRA	<input type="checkbox"/> Courts	<input type="checkbox"/> Loss of Coverage	Effective date of change
<input type="checkbox"/> Marriage	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Other (please explain): _____			

SPOUSE

Last name	First name	M.I.	Social security no.
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Sex	Birthdate	Existing patient	PCP name	PCP I.D. no.
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Are you applying for (check all that apply): Medical Dental Life Vision Are you Handicapped/Disabled? Yes No

Are the dependent children the biological children of either the applicant, spouse or both? Yes No

If no, please complete a Certification of Dependency form. You can download one from www.bcbsga.com.

CHILD 1

Last name	First name	M.I.	Social security no.
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Sex	Birthdate	Existing patient	PCP name	PCP I.D. no.
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Are you applying for (check all that apply): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision	Are you Handicapped/Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	College student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fill out below boxes
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Name of college	State	Date first attended college	Anticipated graduation date
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CHILD 2

Last name	First name	M.I.	Social security no.
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Sex	Birthdate	Existing patient	PCP name	PCP I.D. no.
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Are you applying for (check all that apply): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision	Are you Handicapped/Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	College student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fill out below boxes
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Name of college	State	Date first attended college	Anticipated graduation date
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CHILD 3

Last name	First name	M.I.	Social security no.
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Sex	Birthdate	Existing patient	PCP name	PCP I.D. no.
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Are you applying for (check all that apply): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision	Are you Handicapped/Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	College student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fill out below boxes
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Name of college	State	Date first attended college	Anticipated graduation date
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If you have additional dependents, please attach a separate sheet.

RIGHTS AND OBLIGATIONS

I hereby apply for (a) the medical coverage specified in the Contract between my Employer and Blue Cross and Blue Shield of Georgia, Inc. and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., (hereinafter referred to as the Company) and (b) if so indicated, life insurance provided by the Group Insurance Contract issued by Greater Georgia Life Insurance Co. to my Employer for myself and my eligible family members.

I understand and agree that the effective date of coverage will be governed by the stipulations of the Group Application and the Master Group Contract under which this application is made. I understand that membership will continue according to the terms of the contract between my Employer and the Company. I hereby authorize my Employer to periodically deduct any charge due from me here under and to remit same to the Company along with any contribution due from Employer. I understand and agree that the Company reserves the right to change the subscription charges due for this coverage and to increase or decrease the benefits by giving sixty (60) days written notice to my Employer.

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 to the Company and/or Greater Georgia Life Insurance Co. 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 including the information provided in this application are complete and true to the best of my knowledge and belief, and agree that the Company may cancel this coverage within two (2) years from the effective date, for any ineligible family member or one on whom erroneous or intentionally false information has been submitted, personally assuming liability for reimbursement to the Company for any benefit payment made on behalf of such family member. After this contract has been in force for a period of two (2) years during the lifetime of the insured, it shall become incontestable as to the statements in the applications. I understand that I am responsible for giving notice to my Employer of any changes in my status and that of family members which affect coverage.

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 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. O.C.G.A. 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, Inc. or Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

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 select the category that best describes your ethnic background.

- American Indian/Alaskan Native Black/African American Mexican/Mexican American Asian/Asian-American, or Pacific Islander
 Puerto Rican Other Hispanic or Latin White (non-Hispanic) Other _____
 Primary language _____ Secondary language _____

CERTIFICATION AND SIGNATURE

Do you have prior coverage? Yes No

If yes, and portability rules apply, please furnish proof of your prior coverage with this application.

- I declare that all statements and information made hereon are complete and true to the best of my knowledge. I understand that any intentional misstatements or omissions may void all coverage applied for on any member, including myself and all dependents, on this application on a retroactive basis for up to two (2) years from the contract effective date.
- By signing this line, I understand that a pre-existing condition exclusion may apply (except for HMO, Open Access HMO, Blue Essential (Hospital/Surgical) HMO, and in-network POS, Open Access POS and Blue Essential (Hospital/Surgical) POS) up to twelve (12) months under the Company contract, as defined in the benefit booklet.
- I hereby acknowledge that the Company has informed me of the following prior to my enrollment in their health care coverage plan:
- number, mix, and location of participating/network health care providers
 - limitations on choices of participating/network health care providers
 - disclosure of contractual relationship between participating/network provider and the Company.

Employee Signature _____

Date _____

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