Blue Cross and Blue Shield of Georgia
Agent of Record Change Request/ House Correction Form
for Individual Plans

This form shall serve as a request by the Blue Cross and Blue Shield of Georgia **(BCBSGa**) Individual Health Plan member to change from the current agent to a new agent for the purpose of commissions payable on the policy and servicing duties to the policy holder. It will also serve as a House Correction when the policy has not been in force for 12 consecutive months, and is considered a house account.

BCBSGa must receive all completed forms, along with a signed PHI form, by the 15th of the month in order to be effective the 1st of the following month.

By completing and submitting this form, the policyholder understands that this agreement will terminate the commissions payable and the servicing duties of the original writing agent as of the effective date of this approved request.

The new agent agrees that he/she is licensed with BCBSGa and has an Individual Writing Number assigned. Further, this agent agrees that Agent of Record (AOR) contracts are paid at 5% commission, and contracts received via AOR change do not apply to BCBSGa agent sales production or bonus incentives.

Blue Cross and Blue Shield of Georgia
Policy for Individual Plans
(Effective February 17, 2012)

Our goal is to partner with you to conserve your clients who have coverage with Blue Cross and Blue Shield of Georgia (BCBSGa).

Agent Requirements:

1. Agent must be licensed and actively appointed with BCBSGa.
2. Agent must have a BCBSGa Individual writing number.
3. Agent must be appointed with BCBSGa for 12 months.

Guidelines for all changes:

1. The request must be signed by the customer on our BCBSGa form. No other letter or form will be accepted.
2. The "Authorization to Release PHI" form completed in full indicating the new agent's name and signed by the client must accompany the BCBSGa form.
3. Completed forms must be received by BCBSGa by the 15th of the month in order to be effective the 1st of the following month.
4. * Member's Contract must be in place for 12 months prior to Agent of Record Change Request.
5. * Retroactive commission adjustments are not allowed
6. * Commissions will be paid at 5% for all approved Agent of Record Changes. These contracts will not count as new sales, and are excluded from all incentive bonus plans.
7. * Only one Agent of Record Change is permitted per 12 calendar months on each contract.

Communication:

If you submit an Agent of Record Change to BCBSGa that does not meet the above guidelines, you will be notified via fax or email from BCBSGa indicating the reason for the denial.

The agent must fax the completed form along with the Authorization to Release PHI form to: BCBSGa in order for the request to be processed.

Consumer Services
800-327-9255

*** Specific only to AOR Change Requests**

BlueCross BlueShield of Georgia

AOR Change Request – House Correction Form

Please provide the following information

* **All fields are required**

Policy Holder completes the following:

*Policy Holder Name: _____

*Policy Holder HCID or Policy Number: _____

* Policy Original Effective Date: _____

*New Agent's Name:_____

*New Agent's BCBSGa Rep#_____ *New Agent's GA License#_____

*Reason for re-assignment:

Is this is a website issue: Yes_____ No _____

If yes:

* Website applied through: _____

* Website that should have been used: _____

*Signature of Policy holder: _____Date: _____

*Signature of New Agent: _____ Date: _____

*New Agent's Email Address: _____ Phone#: _____

Must complete and attach the Authorization for Use of Disclosure form

Member Authorization Form

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

PART A: MEMBER INFORMATION

Member last name	Member first name	Middle initial	Member date of birth

Member street address	City	State	ZIP code

Daytime telephone number (with area code)	Identification number (see identification card)	Group number (see identification card)

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please check each box that applies and enter first and last name.

☐ **My spouse** (enter first and last name)	☐ **My parents** (if you are over 18 – enter first and last name[s])
☐ **My domestic partner** (enter first and last name)	☐ **My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
☐ **My adult children** (enter first and last name[s])	☐ **Other** (enter first and last name [if you have it], name of company, and how it's related to you)

PART C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be used or released by Blue Cross and Blue Shield of Georgia on my behalf (check only one box):

☐ **All my information**. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Doctor and hospital
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other: _____

I also approve the release of the following types of sensitive information by Blue Cross and Blue Shield of Georgia (check all boxes that apply to you):

☐ **All sensitive information**

OR

☐ **Just information about topics checked below**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse **
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

** I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described below in Part E. I understand that I cannot cancel this approval where the this form has already been used to disclose information.

PART D: PURPOSE OF THIS APPROVAL

☐ To give out the information as shown on this form

OR

☐ For this reason(s): _____

PART E: DATE YOUR APPROVAL EXPIRES

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

☐ One year from the signature date in Part F

OR

☐ Earlier than one year and upon the date, event or condition described below

_____

PART F: REVIEW AND APPROVAL

I have read the contents of this form. I understand, agree, and allow Blue Cross and Blue Shield of Georgia to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Blue Cross and Blue Shield of Georgia does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Blue Cross and Blue Shield of Georgia. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature **X**	Date

DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to member

Legal representative street address	City	State	ZIP code

Signature **X**	Date

Please return the completed form to:
Blue Cross and Blue Shield of Georgia

Be sure to keep a copy of this form for your records.

FOR RECIPIENT OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For internal use only:	Inquiry tracking number