BlueCross BlueShield of Georgia

Georgia
Individual Dental and Vision Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Blue Cross and Blue Shield of Georgia (BCBSGA), premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 206-0913. If you have questions about a previously submitted application, please call 1 (855) 837-8540.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage ☐ Change policy coverage Policy No.________________ ☐ Add dependent(s) to current coverage Policy No.______________________

Enrollment

You may apply for coverage at any time during the calendar year. Your Effective Date will be the first day of the following month after receipt of your application and premium. Your benefit and enrollment elections are intended to remain the same until your renewal date. For existing members, changes to your coverage can only be made at your renewal date, unless you have a qualifying event as defined below. Notice of a qualifying event must be received by Blue Cross and Blue Shield of Georgia within 31 days of the qualifying event. In the case of a future Loss of Minimum Essential Coverage or renewal of non-calendar year health plan coverage, an application may be submitted up to 30 days in advance of the qualifying event date.

Qualifying Events for Existing Members

Please check the qualifying event:

- ☐ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;
- ☐ Loss of Minimum Essential Coverage due to dissolution of marriage/domestic partnership;
- ☐ Marriage/Domestic Partnership;
- ☐ Birth, or adoption or placement for adoption or appointment of guardianship;
- ☐ Moved to a new exchange service area;
- ☐ Released from incarceration;
- ☐ Death of a family member enrolled under your current coverage;
- ☐ Renewal of non-calendar year health plan coverage;
- ☐ Court ordered coverage including child support order; and
- ☐ Other Qualifying Event: ________________________ (Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events.)

Please provide the date of the qualifying event checked above: ______________________

Blue Cross and Blue Shield of Georgia, Inc., is an independent licensee of the Blue Cross and Blue Shield Association.
The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Coverage Effective Date for Qualifying Events

If you are applying due to a qualifying event and your application is approved, your effective date is as follows:

- In the case of birth, adoption or placement for adoption or appointment of guardianship or court ordered coverage including child support order, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship or the mandated effective date within the court order; or
- In the case of marriage/domestic partnership, loss of Minimum Essential Coverage, release from incarceration, death of a family member under your current coverage or renewal of non-calendar health plan coverage, coverage is effective on the first day of the month following receipt of your application.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*
Home Address			
City	State	ZIP	County
Billing Address (street and P.O. Box if applicable			
City	State	ZIP	
Marital Status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of Birth	
Primary Phone Number	Secondary Phone Number	E-mail*	

**This information is used for internal purposes only and will not be disclosed.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner
Social Security Number*	Sex ☐ M ☐ F	Date of Birth	

**This information is used for internal purposes only and will not be disclosed.*

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your children, or your spouse's or Domestic Partner's children (to the end of the calendar month in which they turn age 26). (List all dependents beginning with the eldest.)

Last Name	First Name	MI	Sex	Date of Birth mm/dd/yyyy	Social Security Number*	Relationship to Applicant
			M ☐ F ☐			☐ Child ☐ Other:_________
			M ☐ F ☐			☐ Child ☐ Other:_________
			M ☐ F ☐			☐ Child ☐ Other:_________
			M ☐ F ☐			☐ Child ☐ Other:_________
			M ☐ F ☐			☐ Child ☐ Other:_________

**This information is used for internal purposes only and will not be disclosed.*

Are any of the applicants listed on the application currently incarcerated (except pending disposition of charges)? ☐ Yes ☐ No

If YES, who? ____

Preferred written language? (Optional)

☐ English (ENG)

☐ Spanish (SPN)

Preferred spoken language? (Optional)

☐ English (ENG)

☐ Spanish (SPN)

Section E – Dental Coverage

Select your plan option: These plans *include* pediatric dental Essential Health Benefits to the end of the month in which the enrollees turn age 19:

☐ BCBSGA Dental Pediatric - 1FS0

☐ BCBSGA Dental Family - 1FS1

☐ BCBSGA Dental Family Enhanced - 1FS2

These plans do *not* include pediatric dental Essential Health Benefits that are required by the Affordable Care Act. You must have another dental (see above plans) or medical plan that has the pediatric dental Essential Health Benefits.

☐ Dental Prime Plan A - 1RBG

☐ Dental Prime Plan B - 1RBH

☐ Dental Prime Plan C - 1RBJ

Section F – Other Dental Coverage

Do you, or anyone applying for coverage, currently have dental care coverage? ☐ Yes ☐ No

If YES, please provide the following:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage

Will you be terminating this coverage if approved for BCBSGA coverage? ☐ Yes ☐ No

If **YES**, what is the termination date? ___________________________

Section G- Vision Coverage

Supplemental vision coverage is also available. In order to enroll in this coverage, you must enroll in one of the dental coverage options, except for BCBSGA Dental Pediatric, in this application. If you have enrolled in one of the dental plans above and would like to add vision coverage, please select your plan option below.

☐ Blue View Vision – 1RYE*

Select who you are enrolling (applies to individuals listed on this application only):

☐ Applicant only

☐ Applicant & all dependent children listed

☐ Applicant & Spouse or Domestic Partner only

☐ Applicant, Spouse or Domestic Partner and all dependent children listed

*This plan does not include pediatric vision Essential Health Benefits that are required by the Affordable Care Act.

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- I understand that although BCBSGA requires payment with my application, sending my initial premium with this application, and the receipt of my payment by BCBSGA, does not mean that coverage has been approved. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, BCBSGA reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that if my application is denied, my bank account or credit card will not be charged.
- I am responsible to timely notify BCBSGA of any change that would make me or any dependent ineligible for coverage.
- I understand BCBSGA may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any BCBSGA automatic debit process and will only occur each time I send a check to BCBSGA. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between BCBSGA and myself.
- I understand I am applying for individual dental or individual dental and vision coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is at least 18 years of age; he or she is mentally competent; he or she 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.
- ☐ By checking this box, I authorize and expressly consent that BCBSGA and its affiliated companies may send e-mail communications instead of sending communications by mail, including but not limited to legally required Plan Notices and underwriting, enrollment and billing and explanation of benefits statements, to the e-mail address I have provided on this Application. I understand that I can revoke this authorization or request paper copies at any time free of charge by contacting BCBSGA customer service or online at www.bcbsga.com.
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by BCBSGA in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits or cancellation of my coverage(s).
- I certify each Social Security Number listed on this application is correct.

I give this authorization for and on behalf of any eligible dependents and myself if covered by BCBSGA. I am acting as their agent and representative.

I hereby acknowledge that BCBSGA has informed me of the following prior to my enrollment in their dental care coverage plan:

- number, mix and location of participating/network health care providers
- limitations of choices of participation/network health care providers
- disclosure of contractual relationship between participation/network provider and BCBSGA.

This application cannot be altered by the applicant to BCBSGA absent the acknowledgement and consent of BCBSGA.

SIGN HERE	Signature	Date
	Signature of Applicant* or Legal Representative X	Date
	Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
	Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

To be completed by your BCBSGA-appointed agent/broker:

Did you see the proposed subscriber and spouse/domestic partner, if applying at the time this application was executed? ☐ Yes ☐ No

If **NO**, please explain: ____

I certify to the best of my knowledge and belief, the responses herein are accurate.

<table>
<tr><td colspan="3">Agent/Broker Signature
X</td><td>Date</td></tr>
<tr><td colspan="2">Agent/Broker Name (please print)</td><td colspan="2">Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No.</td></tr>
<tr><td>Agent/Broker ID/TIN</td><td>Agency ID/Parent TIN</td><td colspan="2">City State ZIP</td></tr>
<tr><td>Agent/Broker Phone No.</td><td>Agent/Broker Fax No.</td><td colspan="2">Agent/Broker E-mail</td></tr>
<tr><td colspan="2">GA (if applicable)</td><td colspan="2">GA code (if applicable)</td></tr>
</table>

Conditional Receipt

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

BCBSGA has received from the named Applicant an advance deposit equal to the first month's dues together with an application for designated dental 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 BCBSGA, 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 waive 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 Blue Shield Georgia Customer Service at 1 (855) 402-9635 or P.O. Box 105370, Atlanta, GA 30348-5370.

Please mail this application to the following address:

Blue Cross Blue Shield of Georgia

PO BOX 659806

SAN ANTONIO, TX 78265-9106

or

Fax to: 1 (800) 848-2512

Payment Methods for Individual Applications – Georgia

BlueCross BlueShield Healthcare Plan of Georgia

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

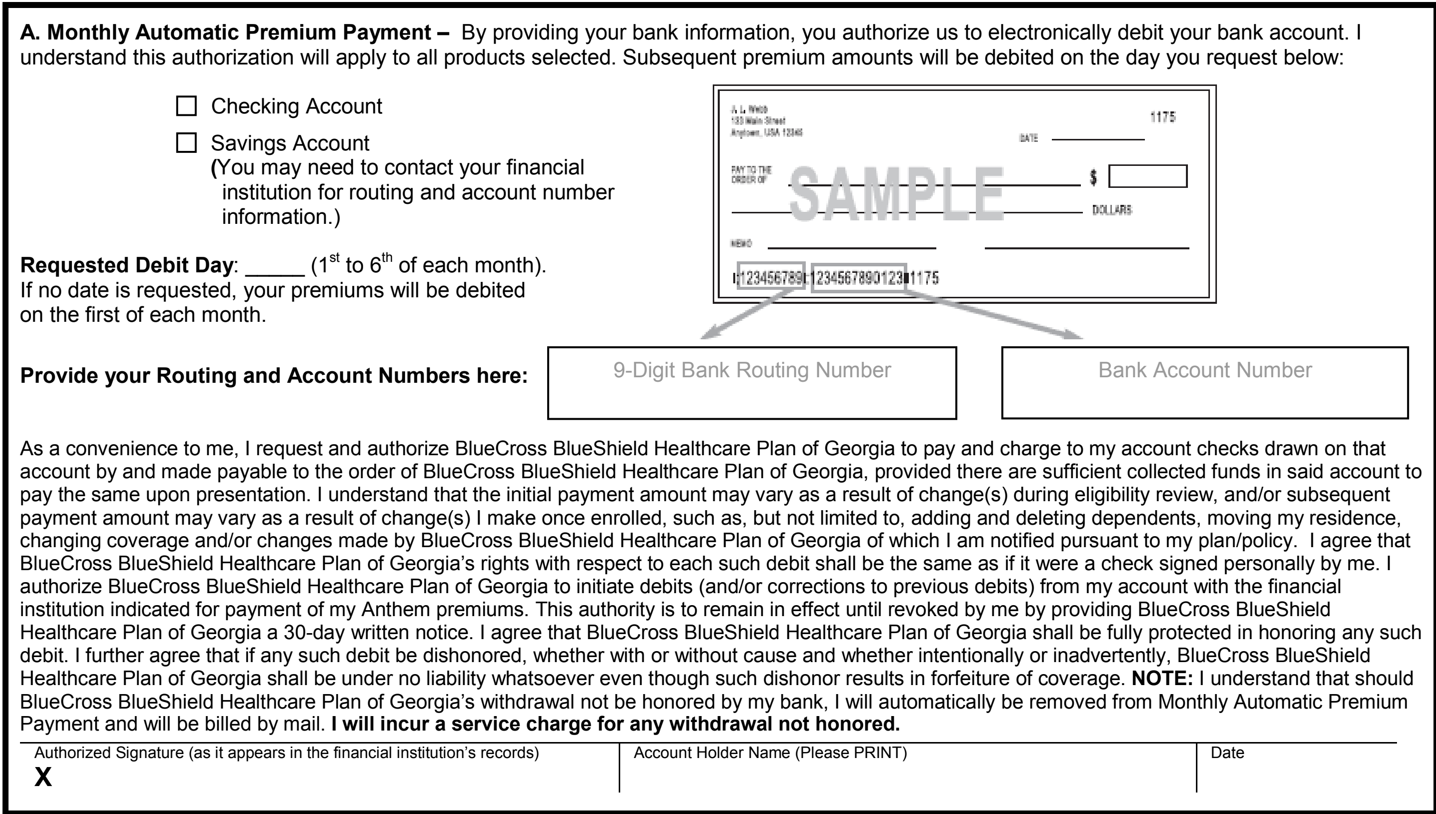
Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

- ☐ Monthly Automatic Premium Payment (complete Section A)

☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

- ☐ Paper Check*
- ☐ Electronic Check (complete Section B)
- ☐ Credit / Debit Card (complete Section C)



A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

- ☐ Checking Account
- ☐ Savings Account
  (You may need to contact your financial institution for routing and account number information.)

Requested Debit Day: _____ (1st to 6th of each month).
If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize BlueCross BlueShield Healthcare Plan of Georgia to pay and charge to my account checks drawn on that account by and made payable to the order of BlueCross BlueShield Healthcare Plan of Georgia, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by BlueCross BlueShield Healthcare Plan of Georgia of which I am notified pursuant to my plan/policy. I agree that BlueCross BlueShield Healthcare Plan of Georgia's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize BlueCross BlueShield Healthcare Plan of Georgia to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing BlueCross BlueShield Healthcare Plan of Georgia a 30-day written notice. I agree that BlueCross BlueShield Healthcare Plan of Georgia shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, BlueCross BlueShield Healthcare Plan of Georgia shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should BlueCross BlueShield Healthcare Plan of Georgia's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

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

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize BlueCross BlueShield Healthcare Plan of Georgia to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by BlueCross BlueShield Healthcare Plan of Georgia of which I am notified pursuant to my plan/policy. I agree that BlueCross BlueShield Healthcare Plan of Georgia shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, BlueCross BlueShield Healthcare Plan of Georgia shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. BlueCross BlueShield Healthcare Plan of Georgia **accepts Visa ☐ and MasterCard ☐.**

Card Number:	Expiration Date:	
Billing address for this Credit / Debit Card:	**City:**	**Zip Code:**

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize BlueCross BlueShield Healthcare Plan of Georgia either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When BlueCross BlueShield Healthcare Plan of Georgia uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield name and symbol is a registered mark of the Blue Cross and Blue Shield Association.