

Application Instructions

Application Instructions For Blue Cross Blue Shield of Georgia

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

**Don't forget to enclose a check for the required payment made payable to:
Blue Cross Blue Shield of Georgia!**

Mail completed application and check to:

**HealthInsurance-Nation
11675 Century Drive, Suite A
Attn: New Enrollment
Alpharetta, Ga 30009**

Fax Completed Application to:

**Toll Free Fax: 1-800-517-3103
Local Fax: 770-475-7593**

**Toll Free: 1-800-831-3270
Local: 770-475-7562
Mon - Fri: 7:45am - 9pm EST**

HealthInsurance-Nation.com will review your application for completeness and accuracy before we submit it to Blue Cross Blue Shield of Georgia for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at **(800)866-2627** or e-mail us at **Ted@USA-HealthInsurance.com**

Fax Cover Sheet



Fax Completed Application to:
Toll Free Fax: 1-800-517-3103
Local Fax: 770-475-7593

Toll Free: 1-800-831-3270
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HealthInsurance-Nation
11675 Century Drive, Suite A
Alpharetta, Ga 30009
ted@usa-healthinsurance.com

| | |
|------------------------------|---------------|
| To: Edward W. Officer | From: |
| Fax #: 770-475-7593 | Pages: |
| Phone #: 770-475-7562 | Date: |
| Re: Enrollment Form | CC: |

Message:

Please contact us if you have any questions regarding the application or the application process. You may reach us at **770-475-7562** or e-mail us at **ted@usa-healthinsurance.com**.



Individual/Family Dental Plan Enrollment Application

If you are a BCBSGA subscriber, please enter your current BCBSGA group number and/or member ID number.

MEMBER ID NO.

FOR BCBSGA USE ONLY:

DCN#

Billing Type

Monthly (*By checking account deduction only. Please complete the enclosed Bank Draft Authorization form.*)

Applicant Information - Applicant must complete this section.

| | | | | | | |
|--|--|--|--|-------------------------------|---|---|
| Last Name <input type="text"/> | | First Name <input type="text"/> | | MI <input type="text"/> | Social Security No. <input type="text"/> | |
| Home Phone No. <input type="text"/> | | Business Phone No. <input type="text"/> | | Age <input type="text"/> | Sex <input type="radio"/> M <input type="radio"/> F | Marital Status <input type="radio"/> Single <input type="radio"/> Married |
| Date of Birth <input type="text"/> | | Home Address (Must be complete. P.O. Box not acceptable) <input type="text"/> | | | | |
| Billing Address (If different or P.O. Box) <input type="text"/> | | City <input type="text"/> | | | | |
| State <input type="text"/> | | Zip Code <input type="text"/> | | City <input type="text"/> | | State <input type="text"/> |
| Zip Code <input type="text"/> | | City <input type="text"/> | | State <input type="text"/> | | Zip Code <input type="text"/> |

Spouse to Be Insured - Signature required below.

| | | | | |
|---|------------------------------------|---|---------------------------------------|---|
| Last Name of Spouse <input type="text"/> | First Name <input type="text"/> | Sex <input type="radio"/> M <input type="radio"/> F | Date of Birth <input type="text"/> | Social Security No. <input type="text"/> |
|---|------------------------------------|---|---------------------------------------|---|

Children to Be Insured - Signature required below.

| | | | | |
|---|------------------------------------|---|---------------------------------------|---|
| 1. Last Name of Child <input type="text"/> | First Name <input type="text"/> | Sex <input type="radio"/> M <input type="radio"/> F | Date of Birth <input type="text"/> | Social Security No. <input type="text"/> |
| 2. Last Name of Child <input type="text"/> | First Name <input type="text"/> | Sex <input type="radio"/> M <input type="radio"/> F | Date of Birth <input type="text"/> | Social Security No. <input type="text"/> |
| 3. Last Name of Child <input type="text"/> | First Name <input type="text"/> | Sex <input type="radio"/> M <input type="radio"/> F | Date of Birth <input type="text"/> | Social Security No. <input type="text"/> |
| 4. Last Name of Child <input type="text"/> | First Name <input type="text"/> | Sex <input type="radio"/> M <input type="radio"/> F | Date of Birth <input type="text"/> | Social Security No. <input type="text"/> |

Signatures (Required)

If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. If the responsible adult is not the natural parent, please submit court papers authorizing guardianship. I understand that coverage is subject to all conditions and provisions specified in the Policy. By submitting an application for coverage, I have authorized every provider furnishing care to disclose all facts pertaining to our care, treatment, and physical conditions, upon your request. I agree to assist in obtaining this information if needed. I understand that receipt of money with this application does not create BCBSGA coverage. Coverage will come into effect only on approval by BCBSGA.

| | | | |
|--|--------------|---|--------------|
| Signature of Applicant /Parent or Legal Guardian X | Today's Date | Signature of Applicant's Spouse X | Today's Date |
|--|--------------|---|--------------|

Agent Information

| | | | |
|---|------------------------------|--------------------------------|--------------|
| Name of Agent (Print) Edward W. Officer | Agent Number 10297 | Signature of Agent X | Today's Date |
| Rep No. <input type="text"/> | | | |

FOR BCBSGA USE ONLY

| | | | |
|-----------------------------------|---------------------------------------|--|--|
| Group No. <input type="text"/> | Member ID No. <input type="text"/> | Agent Tax I.D. No. <input type="text"/> | Effective Date <input type="text"/> |
| Area <input type="text"/> | By <input type="text"/> | Date <input type="text"/> | |



| | | | | | | | | | |
|---------------------|--|--|--|--|--|--|--|--|--|
| SOCIAL SECURITY NO. | | | | | | | | | |
| | | | | | | | | | |

BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS

I hereby authorize **Blue Cross and Blue Shield of Georgia, Inc.** to draw checks, drafts, orders or electronic funds transfer (EFT) upon my account at the:

| | |
|------------------------|-------------------------------|
| _____ | _____ |
| NAME OF BANK | CHECKING ACCOUNT NUMBER |
| _____ | _____ |
| STREET ADDRESS OF BANK | CITY, STATE, ZIP CODE OF BANK |

for the purpose of paying premiums on insurance issued by Blue Cross and Blue Shield of Georgia, Inc.

I understand if any check, draft, order or EFT transmission is returned due to **payment stopped** or **authorization cancelled**, this will be considered as my request to be billed directly.

| | |
|---------------------------|---------------------------|
| _____ | _____ |
| CONTRACT HOLDER'S NAME | SOCIAL SECURITY NUMBER |
| _____ | _____ |
| CONTRACT HOLDER'S ADDRESS | CITY, STATE, AND ZIP CODE |

| | | | |
|-------------------------------------|----------|-----------------------------|-------|
| _____ | X | _____ | _____ |
| PRINTED SIGNATURE OF ACCOUNT HOLDER | | SIGNATURE OF ACCOUNT HOLDER | DATE |

NOTE: A VOIDED CHECK MUST BE ATTACHED TO THIS APPLICATION.

First request for bankdraft plan

Complete entire form and attach a voided check.

INSTRUCTIONS FOR COMPLETING THE BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS

Automatic Premium Payment Plan

What is it - A special arrangement for payment of premiums automatically each month to relieve you of concern with due dates and the possibilities of having your insurance lapse unintentionally.

Who can use it - Bankdraft is an extra convenience for you. It is available if you maintain a regular checking account at your bank and make arrangements with your bank to honor automatic checks and electronic fund transfers.

How it works - To initiate the bankdraft, you must complete the authorizations above.

INSTRUCTIONS

1. Complete as follows:

- A. Fill in the name of your bank, branch, branch number (*if any*) and the city or state in which the bank or the branch is located.
- B. Print the name of your account exactly as it appears on your bank statement or check.
- C. Include your checking account number. It will usually be found below the signature line of your personal checks.
- D. Sign your name exactly as you do on your personal checks. If there is more than one depositor, all should sign.
- E. Include the date you signed the authorizations.

2. Attach a VOIDED check and this completed form. Please be sure the sample check is drawn on the same account as will be used for the automatic premium payment plan.

3. The coverage provided by this policy may be terminated by you upon thirty (30) days **written** notice.

4. Written notice thirty (30) days in advance as stated above in No. 3 is preferred. However, if any check is returned for **payment stopped** or **authorization cancelled**, this will be considered as your request to be billed directly. No further checks will be presented for payment to your bank. If a check is returned for any other reason, you will be notified by Blue Cross and Blue Shield of Georgia of what is required to pay the premium.

INTERNAL USE ONLY

| |
|---------------|
| DCN #: _____ |
| BANK #: _____ |