

Blue Cross Short Term Application Checklist

- _____ 1. Complete a separate application for each family member.
- _____ 2. Include the first month's premium for each application in the form of a credit or debit card.
- _____ 3. **All questions must be answered.** Please initial any corrections.
- _____ 4. Please fax your application directly to Blue Cross at 404-682-3237 for fastest approval. Please fax me a copy also at 770-452-9336 so that I will be able to service you best as your agent.

Or you may mail your completed application and check (Make check payable to Blue Cross) to:

Georgia Health Insurance, Inc.
4514 Chamblee Dunwoody Rd., # 279
Atlanta, GA 30338

Please call us with any questions at (770) 452-9335, Toll Free at (866) 449-9335 or e-mail us at tpotter@ga-health-insurance.com



Short Term Medical Application

Mail Code: G00302

3350 Peachtree Road, NE Atlanta, GA 30326

Fax: (404) 682-3237

Requested Effective Date

Month	Day	Year
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NOTE: The actual effective date is contingent upon the receipt of your properly completed application and the correct payment.

APPLICANT'S NAME (LAST, FIRST, MIDDLE)	SEX	BIRTHDATE (MM/DD/YY)	APPLICANT SOCIAL SECURITY NUMBER
RESIDENTIAL ADDRESS	CITY	STATE	ZIP
COUNTY	DAY TELEPHONE	EVENING TELEPHONE	

- Are you applying for other medical coverage with BCBSGa? Yes No
- Please answer the following questions completely and accurately. If you check **Yes** to questions 1-4 you are **not eligible** for coverage. Yes No
- Will you or any person to be insured have any other hospital, major medical or group health insurance in force on the effective date of this plan? Yes No
 - Have/ are you: Now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment? Yes No
Note: Pregnant women are not eligible to apply
 - Is your weight greater than the maximum weight as indicated in the charts below? Yes No

Height	Max Weight	Height	Max Weight	Height	Max Weight
4'0"	122	5'0"	196	6'0"	257
4'1"	126	5'1"	199	6'1"	273
4'2"	132	5'2"	202	6'2"	281
4'3"	138	5'3"	207	6'3"	291
4'4"	142	5'4"	211	6'4"	298
4'5"	149	5'5"	215	6'5"	307
4'6"	154	5'6"	219	6'6"	314
4'7"	161	5'7"	229		
4'8"	166	5'8"	235		
4'9"	172	5'9"	241		
4'10"	189	5'10"	246		
4'11"	193	5'11"	252		

Height	Max Weight	Height	Max Weight	Height	Max Weight
4'6"	158	5'6"	230	6'6"	322
4'7"	165	5'7"	234	6'7"	332
4'8"	170	5'8"	249	6'8"	338
4'9"	177	5'9"	256	6'9"	349
4'10"	182	5'10"	262	6'10"	355
4'11"	189	5'11"	270	6'11"	366
5'0"	195	6'0"	277	7'0"	374
5'1"	202	6'1"	285	7'1"	384
5'2"	215	6'2"	292	7'2"	391
5'3"	218	6'3"	300	7'3"	401
5'4"	222	6'4"	307		
5'5"	226	6'5"	316		

4. For any of the following conditions, within the last 5 years, have you received any abnormal test results or medical or surgical treatment, or consulted a health care professional or taken medication for:
- Heart disorder including but not limited to heart attack or chest pain; chronic respiratory conditions including, chronic obstructive pulmonary disease or emphysema; ulcers; colitis or Crohn's disease; liver, hepatitis, Rheumatoid Arthritis, acquired immune deficiency syndrome (AIDS) and related immune system disorders, or have tested positive for HIV? Yes No
 - Uncorrected gall bladder disease or gall stones; stroke or circulatory system disorders; leukemia; kidney disease, undergoing kidney dialysis; diabetes type I or type II; cancer, tumor or internal cyst; alcoholism or alcohol abuse, chemical/substance dependency or drug abuse? Yes No

PLAN SELECTION		
Benefit Period <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> 150 days <input type="checkbox"/> 180 days	Deductible Amount <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500	Plan Pays After Deductible <input type="checkbox"/> 80%

- 1 - Do you currently have health care coverage? Yes No
- 2 - Did you have creditable coverage within the past 63 days? Yes No

Note: Please make a copy of the signed application for your records prior to submitting to Blue Cross Blue Shield of Georgia.

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

Blue Cross Blue Shield of Georgia (BCBSGa) has received from the named Applicant an advance deposit equal to the first 30 day's premium 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 30 day's premium 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 30 days, please contact Blue Cross Blue Shield of Georgia Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

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 Blue Shield of Georgia Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

Short Term Medical Application *continued*

Notice to Applicant Concerning Personal Health and Financial Information: This is to notify you that BCBSGa has the right to collect personal health and financial information about you or any family members listed on this form and to use and disclose that information as described in the Notice of Privacy Practices.

Payment Method: 1st Month Payment Check Credit Card
Subsequent Monthly Payments Electronic Funds Transfer (EFT) Credit Card

Electronic Funds Transfer Authorization

It's convenient! You can authorize Blue Cross Blue Shield of Georgia (BCBSGa) to automatically deduct your premium from your checking account each month. Once your application is approved, we will work with your bank to initiate this service.

Simply complete this section and be sure to include your first month's premium when you return your completed application. Your policy must be "pre-paid" with no money due before EFT can begin each month.

For: (Applicant's Name) _____

Applicant's Address: _____

To: (Name of Your Bank) _____

Bank Address: _____

Bank Routing Number: _____ Account Number: _____

As a convenience to me, I authorize you to pay and charge to my account drafts drawn on my account by and payable to the order of Blue Cross Blue Shield of Georgia, provided there are sufficient funds in my account to pay the same upon presentation. I agree that your rights in respect to each such draft are the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and received by you. I agree that you shall be fully protected in honoring any such draft. I further agree that if such drafts were dishonored, whether with or without cause and whether internationally or inadvertently, you shall be under no liability whatsoever even if such dishonor results in loss of this insurance.

The Electronic Funds Transfer agreement provided by this policy may be terminated by calling BCBSGa Customer Service (800) 718-8831 at least 7 days in advance of your next due date.

X _____ / /
 Signature (exactly as it appears on bank records) Account# Date (mm/dd/yyyy)

Credit Card Authorization for Initial Payment

You may choose to make your initial premium payment by check, money order or credit card. Credit card payment is available for your initial premium payment only. If choosing to pay by credit card, you must complete all of the following information:

MC Visa Discover Credit Card # _____ / /
 Expiration Date (mm/dd/yyyy)

The Credit Card Authorization provided by this policy may be terminated by calling BCBSGa Customer Service (800) 718-8831 at least 7 days in advance of your next due date.

I authorize Blue Cross Blue Shield to bill my VISA, MasterCard or Discover account.

X _____ **X** _____ / /
 Name as it appears on Credit Card (Please Print) Cardholder's Signature Date (mm/dd/yyyy)

I, the undersigned, hereby apply for the coverage indicated for my eligible family members and myself. 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 by Medical Underwriting, 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. BCBSGa reserves the right to change any applicable premiums for new coverage issued after the expiration date of this policy. 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 fraudulent or intentionally misleading 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.

I understand and agree that under this contract:

- You may request an effective date. If BCBSGa receives the properly completed application and correct payment before the date you requested, and your application is approved, your coverage will begin at 12:01 AM ET on the day you request.
- If you do not request a specific effective date and you or your agent/broker mails or delivers your application and correct payment to BCBSGa, and your application is approved, BCBSGa will assign the effective date as 12:01 AM ET the day after receipt by BCBSGa.
- 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 bind coverage or waive the answer to any question in this application, to pass insurability, to waive any of BCBSGa's rights or requirements or to make or alter any contract.
- I acknowledge that I have read, or have had read to me, the completed application. I realize that if I omit any information or provide any fraudulent or, intentionally misleading or incomplete information that is considered fraud or material misrepresentation, this can result in claim denial and/or cancellation of this coverage. I agree to repay promptly any benefit payment to which my dependents or I was not entitled. I understand that the contract applied for will not provide benefits for any expenses incurred on account of any condition that manifested itself before the contract effective date, as explained in the "Exclusions" section of my contract. I also understand that this is not a continuation of any previous medical program, including any prior Short Term Medical contract.

Check the appropriate box:

I DO UNDERSTAND **I DO NOT UNDERSTAND**

X _____ / /
 Applicant's Signature Date (REQUIRED)

X _____
 Agent Signature Print Name Rep No.

_____ Fax Number