



INDIVIDUAL PRODUCTS CHANGE REQUEST

Please Print Clearly. Use Black Ink Only.
DO NOT WRITE IN SHADED AREA

LBG#:

DCN:

PLEASE REFER TO YOUR CONTRACT FOR ELIGIBILITY REQUIREMENTS

1. Name (Last, First, MI) as shown on ID card	2. Date of Birth Mo Day Yr	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight	Height	4. Present Contract Number
5. Reason for Change <input type="checkbox"/> Death <input type="checkbox"/> Adoption <input type="checkbox"/> Name Change (#13) <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Change of Address (#17) <input type="checkbox"/> Change Coverage (#11) <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Divorce <input type="checkbox"/> Left Employer <input type="checkbox"/> Unmarried Student Dependent <input type="checkbox"/> Other					Date of Change Mo Day Yr

CHECK ONLY THE CHANGE(S) YOU WISH TO MAKE, THEN FILL IN THE NECESSARY INFORMATION

6. <input type="checkbox"/> Adding new dependent(s) - Include student dependents. List dependent(s) to be added below. Place an "A" in the "Add" column for each dependent to be added. Attach Handicapped/Disabled Member Certification for each handicapped dependent.	7. <input type="checkbox"/> Remove dependent(s) - CHANGE TO SINGLE COVERAGE. List Dependent(s) to be removed below. Place an "R" in the "Remove" column for each dependent to be removed.	8. <input type="checkbox"/> Remove dependent(s) - BUT RETAIN FAMILY COVERAGE. List Dependent(s) to be removed below. Place an "R" in the "Remove" column for each dependent to be removed.
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Type Contract		DEPENDENT SECTION															
Ind.	Fam.	Change Effective			Last Name	First Name	MI	Add	Remove	Relationship to You	Birthdate			Weight	Height	College Student	Handicapped
		Mo	Day	Year							Mo	Day	Year				
										<input type="checkbox"/> Husband <input type="checkbox"/> Wife							
										SSN:							
										<input type="checkbox"/> Son <input type="checkbox"/> Daughter							
										<input type="checkbox"/> Son <input type="checkbox"/> Daughter							
										<input type="checkbox"/> Son <input type="checkbox"/> Daughter							
										<input type="checkbox"/> Son <input type="checkbox"/> Daughter							
										<input type="checkbox"/> Son <input type="checkbox"/> Daughter							

9. Are you or your spouse the biological parent of the child / children listed above?
 Yes No **If "NO," a Certification of Dependency form must be completed and attached.**

10. <input type="checkbox"/> Change Coverage and/or Deductible to:	11. <input type="checkbox"/> Cancel my contract effective: _____ MM DD YY
12. <input type="checkbox"/> My name has changed to: My new name is: _____	13. <input type="checkbox"/> My contract number is incorrect My correct contract number is: _____

14. <input type="checkbox"/> Remove me from the contract and change the contract from my name to Complete Blocks 15a-15d):	14a. Name	14b. Birthdate Mo Day Yr	14c. Social Security Number	14d. Relationship
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15. Another family member and I currently have separate Blue Cross and Blue Shield of Georgia contracts. I request that our contracts be combined as specified:
 Transfer his/her coverage to my contract
 Transfer my coverage to his/her contract Contract #: _____
Submit a Change Request for both contracts and complete Blocks 16a-16d.

15a. Name of other family member	15b. Birthdate Mo Day Yr	15c. Social Security Number	15d. Relationship
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16. My address has changed. My new Address is: _____
 Street City County State Zip Code

17. Other (Explain) _____

18. If there are any questions, I may be reached at the following telephone number: _____
 Area Code Phone Number /

White - BCBSGA Copy

Canary - Medical Underwriting

Pink - Applicant

An Independent Licensee of the Blue Cross Blue Shield Association

If you checked blocks 6 or 11, answer ALL of the following questions with respect to each person for whom you are applying or upgrading benefits.

(A) Have any of the persons listed ever had medical advice, examination, treatment or any known indications of health problems in regard to the following:

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 22. <input type="checkbox"/> | <input type="checkbox"/> | Do you now or have you ever, or anyone you are applying for, ever used tobacco products? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23. <input type="checkbox"/> | <input type="checkbox"/> | Is any person listed on this application pregnant? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. <input type="checkbox"/> | <input type="checkbox"/> | Do any complications exist? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

(B) Has any person listed on the application:

1. Ever been advised to undergo a surgical operation which was not performed?
2. Been advised to undergo surgery within the next six months?
3. Been refused or had health insurance cancelled within last 5 years?
4. Is anyone listed on the application in impaired mental or physical health?

(C) NAME AND COMPLETE ADDRESS OF DOCTOR(S) SEEN BY YOU WITHIN LAST 2 YEARS

NAME AND COMPLETE ADDRESS OF DOCTOR(S) SEEN BY SPOUSE WITHIN LAST 2 YEARS

(D) List below full details to questions answered "YES" in Sections A and B, if doctor has been seen in last 2 years, give reason of visit. If additional space is needed, list on a separate sheet of paper and attach to this application.

Person Treated	Name of Illness or Disorder	Type of Treatment Received	Treatment Dates		Name and Address of Attending Physician
			From	To	

PLEASE READ BEFORE SIGNING;

I hereby apply to Blue Cross and Blue Shield of Georgia, Inc. I understand and agree that if my application is accepted benefits will not be effective until the date shown on the Identification Card of the Subscriber's Contract(s) to be issued to me, which will set forth the benefits to be received and the conditions upon which they will be made available. I understand that benefits of this Plan are not available for conditions which require a waiting period until this contract(s) has been continuously in effect for the required waiting period(s) described in my contract(s).

I agree that any contract which may be issued to me shall be binding only if all statements in this application are complete and true to the best of my knowledge and belief, and, further, that notice to and knowledge of your representative is not notice to or knowledge of Blue Cross and Blue Shield of Georgia, Inc., and that the Plan may declare ineffective this coverage if any statement in this application is not complete and true to the best of my knowledge and belief. I also understand that my application is subject to medical underwriting before acceptance. This contract replaces and supersedes all contracts which may have been issued previously to the Subscriber to whom this contract is issued. I do hereby authorize any doctor or hospital to furnish you any and all medical records pertaining to each person listed on this application. I also certify all information contained herein is true to the best of my knowledge and belief.

I hereby acknowledge that Blue Cross and Blue Shield of Georgia/Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSGA/BCBSHP) (as applicable) has informed me of the following prior to my enrollment in their health care coverage plan:

- a. number, mix and location of participating/network health care providers
- b. limitations on choices of participating/network health care providers
- c. disclosure of contractual relationship between participating/network provider and BCBSGA/BCBSHP

Applicant's Signature _____ Date _____ Spouse's Signature _____ Date _____

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 your data confidential. It will be seen only by our 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 practice, please contact Blue Cross and Blue Shield of Georgia, Inc., Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.