



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. Birthdate (mm/dd/yyyy) / /	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight	Height	4. Present Contract Number
Home Address (street and P.O. Box if applicable)					
City		State	Zip	County	
5. Reason for Change <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Adoption <input type="checkbox"/> Left Employer <input type="checkbox"/> Name Change (#13) <input type="checkbox"/> Change of Address (#17) <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Unmarried Student Dependent <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Change Coverage (#11) <input type="checkbox"/> Other _____					Date of Change (mm/dd/yyyy) / /

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

<input type="checkbox"/> 6. 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.	<input type="checkbox"/> 7. 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.	<input type="checkbox"/> 8. 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 (mm/dd/yyyy)	LAST NAME	FIRST NAME	MI	ADD	REMOVE	RELATIONSHIP TO YOU	BIRTHDATE (mm/dd/yyyy)	WEIGHT	HEIGHT	COLLEGE STUDENT	HANDICAPPED
<input type="checkbox"/>	<input type="checkbox"/>	/ /						<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Domestic Partner Social Security Number* 	/ /			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	/ /						<input type="checkbox"/> Son <input type="checkbox"/> Daughter	/ /			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	/ /						<input type="checkbox"/> Son <input type="checkbox"/> Daughter	/ /			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	/ /						<input type="checkbox"/> Son <input type="checkbox"/> Daughter	/ /			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	/ /						<input type="checkbox"/> Son <input type="checkbox"/> Daughter	/ /			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	/ /						<input type="checkbox"/> Son <input type="checkbox"/> Daughter	/ /			<input type="checkbox"/>	<input type="checkbox"/>

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. Change Coverage and/or Deductible to: _____ 11. Cancel my contract effective: _____ mm/dd/yyyy

12. My name has changed to: My new name is: _____ 13. My contract number is incorrect. My correct contract number is: _____

14. Remove me from the contract and change the contract from my name to **(Complete Blocks 14a-14d)**:

14a. Name	14b. Birthdate (mm/dd/yyyy) / /	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. **Contract #:** _____ Transfer my coverage to his/her contract. **Contract #:** _____
Submit a Change Request for both contracts and complete Blocks 15a-15d.

15a. Name of other family member	15b. Birthdate (mm/dd/yyyy) / /	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

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

If you checked blocks 6 or 10, answer ALL of the following questions with respect to each person for whom you are applying or upgrading benefits.

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

(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:

YES	NO		YES	NO			
1.	<input type="checkbox"/>	<input type="checkbox"/>	Impairment of Sight, Speech or Hearing	15.	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Attacks, Convulsions, or Epilepsy
2.	<input type="checkbox"/>	<input type="checkbox"/>	Eyes, Ears, Nose, Throat, Head or Brain Disorder	16.	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse, Drug or Alcohol Abuse
3.	<input type="checkbox"/>	<input type="checkbox"/>	Disease of Endocrine System, Thyroid, Goiter or Diabetes	17.	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder, Anemia, Leukemia, or Hemophilia
4.	<input type="checkbox"/>	<input type="checkbox"/>	Asthma, Sinus, Nasal, Allergies or Lung Disorder	18.	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Cyst or Cancer
5.	<input type="checkbox"/>	<input type="checkbox"/>	High or Low Blood Pressure, Heart Trouble or Vascular Disease	19.	<input type="checkbox"/>	<input type="checkbox"/>	Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Kaposi Sarcoma, Pneumocystis Carinii Pneumonia, or Antibodies to Human T-Lymphotropic Virus Type III (HTLV-III)
6.	<input type="checkbox"/>	<input type="checkbox"/>	Spine Condition or Bodily Deformity	20.	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases such as syphilis, gonorrhea, herpes, genital warts
7.	<input type="checkbox"/>	<input type="checkbox"/>	Disease of Bones or Joints, Arthritis or Rheumatism	21.	<input type="checkbox"/>	<input type="checkbox"/>	Any other Medical or Surgical advice or treatments, hospitalizations, or chronic or recurring minor ailments.
8.	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers or Stomach Disorders	22.	<input type="checkbox"/>	<input type="checkbox"/>	Do you now or have you ever, or anyone you are applying for, ever used tobacco products?
9.	<input type="checkbox"/>	<input type="checkbox"/>	Kidney, Bladder or Prostate Disorder	23.	<input type="checkbox"/>	<input type="checkbox"/>	Is any person listed on this application pregnant?
10.	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder, Liver Disorder, or Hepatitis	24.	<input type="checkbox"/>	<input type="checkbox"/>	Do any complications exist?
11.	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Disturbances or other Female Disorders				
12.	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids, Intestinal or Rectal Disorder				
13.	<input type="checkbox"/>	<input type="checkbox"/>	Hernia				
14.	<input type="checkbox"/>	<input type="checkbox"/>	Nervous or Mental Disorder				

(B) Has any person listed on the application:

YES	NO		
1.	<input type="checkbox"/>	<input type="checkbox"/>	Ever been advised to undergo a surgical operation which was not performed?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Been advised to undergo surgery within the next six months?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Been refused or had health insurance cancelled within last 5 years?
4.	<input type="checkbox"/>	<input type="checkbox"/>	Is anyone listed on the application in impaired mental or physical health?

(C) 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 understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 6 months or more; he or she is mentally competent; he or she, is at least 18 years old; 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.

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

Signature of Applicant (or Custodial Parent's or Guardian's signature if applicant is under age 18) X	Date
Signature of Spouse/Domestic Partner X	Date
Signature of Dependent Child over 18 X	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.

RETURN FORM TO: P.O. Box 4445, Atlanta, Georgia 30302

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