BlueCross BlueShield of Georgia

# INDIVIDUAL PRODUCTS
# AGREEMENT FOR LIST BILL

Bill to: (Name Company) _____ Type of Business: _____

Billing Address: _____
STREET CITY STATE ZIP

Contact Person: _____ Phone: ( ) _____

Agent's Name: _____ Agent's No. _____

INCLUDE THE FOLLOWING PERSONS ON THE ABOVE LIST BILL: ☐ New Case ☐ Add On ☐ Roll Over ☐ Delete

| Name | SSN | 1st MONTH PREMIUM | EMPLOYEE | SPOUSE | DEPENDENT |
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Number of Applications Submitted _____ Total Dollar Amount Submitted _____

**IMPORTANT**

**EMPLOYER'S STATEMENT**

I understand that I am not offering a Group Plan to my employees and that a List Bill is being created only for administrative convenience. I further understand and agree that each applicant will be individually underwritten and policies issued and maintained on that basis. I have read the "STATEMENT TO EMPLOYEE" that I received from my Blue Cross and Blue Shield of Georgia representative.

Authorization (PRINT NAME):_____agrees to receive the premium billing statement for the above applicants who become insured and to send collected premiums to Blue Cross and Blue Shield of Georgia for these persons when due as long as they are employees of the employer. **The premiums are to be payroll deducted and the employer should not pay any portion of the employee premium.** The employer further agrees to receive the premium billing for any future employees of the employer who may become insured. The employer also agrees to abide by the rules and regulations issued by BCBSGA for List Bill. The authorization may be withdrawn at any time by the employer upon 30 days written notice to Blue Cross and Blue Shield of Georgia. **DO NOT CANCEL ANY EXISTING INSURANCE PLAN UNTIL YOU HAVE BEEN NOTIFIED OF APPROVAL.**

By: _____ Title: _____

Date: _____ Witness (AGENT): _____

Please return this form to:
Blue Cross and Blue Shield of Georgia
New Business Sales
3350 Peachtree Rd.
Mail Code: G00302
Atlanta, GA 30326

Independent Licensee of the Blue Cross Blue Shield Association