



General Questionnaire

Blue Cross Blue Shield of Georgia, Inc.
Attn: Underwriting Department
P. O. Box 13047
Roanoke, Virginia 24030
Customer Svc. Phone: 1-800-718-8831
Fax: 1-800-327-9255

Date: _____

Return by: _____

Thank you for your application for health care coverage. To continue processing your application, please provide the following information regarding the health status of _____. Please note that you may use additional paper if necessary. All additional sheets must be signed and dated by the applicant.

1. Physician who supervises the _____ condition:
Name _____ Address _____ Phone # _____
2. What are (or were) the symptoms? _____
3. What did the attending physician call the condition (diagnosis)? _____
4. What date did the condition begin? _____ / _____ / _____
5. What was the date of last symptoms or treatment, including medications? _____ / _____ / _____
6. Description of treatment, including medications: _____

7. Was surgery performed? Yes No **If yes,** list specific surgical procedure(s) and date(s). _____

8. For what condition was the above surgery/medical procedure performed? _____
9. How often has this condition occurred (number of episodes) within the last _____ months? Please list date(s):

10. Have there been ongoing symptoms/treatments related to the condition? Yes No
If yes, please explain. _____
11. Question: _____
Response: _____

(continued on next page)

An independent licensee of the Blue Cross and Blue Shield Association.

Certification

I certify that I have read or have had read to me this completed form. I understand that any answer or statement made on this form that is untrue and is material to the risk assumed by Blue Cross and Blue Shield of Georgia, Inc. may prevent the recovery of benefits under the policy and may also result in the termination or voiding of the policy back to its effective date. I understand that this form will now become part of my application for coverage with Blue Cross and Blue Shield of Georgia, Inc.

Signature of Applicant or Legal Representative

Date____/____/____
mo. / day / year

Signature of Spouse or Other Adult to be covered
(if applying for coverage)

Date____/____/____
mo. / day / year