



**Blue Cross and Blue Shield of Georgia**  
**Agent of Record Change Request/ House Correction Form**  
**for Individual Plans**

This form shall serve as a request by the Blue Cross and Blue Shield of Georgia (BCBSGa) Individual Health Plan member to change from the current agent to a new agent for the purpose of commissions payable on the policy and servicing duties to the policy holder. It will also serve as a House Correction when the policy has not been in force for 12 consecutive months, and is considered a house account.

BCBSGa must receive all completed forms, along with a signed PHI form, by the 15<sup>th</sup> of the month in order to be effective the 1<sup>st</sup> of the following month.

By completing and submitting this form, the policyholder understands that this agreement will terminate the commissions payable and the servicing duties of the original writing agent as of the effective date of this approved request.

The new agent agrees that he/she is licensed with BCBSGa and has an Individual Writing Number assigned. Further, this agent agrees that Agent of Record (AOR) contracts are paid at 5% commission, and contracts received via AOR change do not apply to BCBSGa agent sales production or bonus incentives.



**Blue Cross and Blue Shield of Georgia  
Policy for Individual Plans  
(Effective January 1, 2010)**

Our goal is to partner with you to conserve your clients who have coverage with Blue Cross and Blue Shield of Georgia (BCBSGa).

Agent Requirements:

1. Agent must be licensed and actively appointed with BCBSGa.
2. Agent must have a BCBSGa Individual writing number.

Guidelines for all changes:

1. The request must be signed by the customer on our BCBSGa form. No other letter or form will be accepted.
2. The "Authorization to Release PHI" form completed in full indicating the new agent's name and signed by the client must accompany the BCBSGa form.
3. Completed forms must be received by BCBSGa by the 15th of the month in order to be effective the 1st of the following month.
4. \* Member's Contract must be in place for 12 months prior to Agent of Record Change Request.
5. \* Retroactive commission adjustments are not allowed
6. \* Commissions will be paid at 5% for all approved Agent of Record Changes. These contracts will not count as new sales, and are excluded from all incentive bonus plans.
7. \* Only one Agent of Record Change is permitted per 12 calendar months on each contract.

Communication:

If you submit an Agent of Record Change to BCBSGa that does not meet the above guidelines, you will be notified via fax or email from BCBSGa indicating the reason for the denial.

The agent must fax the completed form along with the Authorization to Release PHI form to: BCBSGa in order for the request to be processed.

**Consumer Services  
877-273-7146**

**\* Specific only to AOR Change Requests**



AOR Change Request - House Correction Form

Please provide the following information

\* All fields are required

Policy Holder completes the following:

\*Policy Holder Name: \_\_\_\_\_

\*Policy Holder HCID or Policy Number: \_\_\_\_\_

\* Policy Original Effective Date: \_\_\_\_\_

\*New Agent's Name: \_\_\_\_\_

\*New Agent's BCBSGa Rep# \_\_\_\_\_ \*New Agent's GA License# \_\_\_\_\_

\*Reason for re-assignment:  
\_\_\_\_\_

*Is this is a website issue:* Yes \_\_\_\_\_ No \_\_\_\_\_

If yes:

\* Website applied through: \_\_\_\_\_

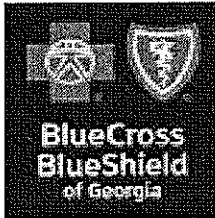
\* Website that should have been used: \_\_\_\_\_

\*Signature of Policy holder: \_\_\_\_\_ Date: \_\_\_\_\_

\*Signature of New Agent: \_\_\_\_\_ Date: \_\_\_\_\_

\*New Agent's Email Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

- Must complete and attach the Authorization for Use of Disclosure form



## Authorization for Use or Disclosure of Protected Health Information (PHI)

*Please print clearly and use only black ink.*

- 1. Small Group  
(2-50 employees)
- 2. Large Group  
(More than 50 employees)
- 3. Individual Coverage

*Please refer to the instructions and  
check one of the above blocks.*

By completing this form, I authorize Blue Cross and Blue Shield of Georgia (BCBSGA), its agents or subsidiaries, to use or disclose my Protected Health Information (PHI) for the purposes stated on this form.

I have the right to revoke this authorization at any time by giving written notice of my revocation to BCBSGA. I understand that my revocation will not affect any action taken before my written revocation notice is received. I also understand that PHI used or disclosed under the provisions of this authorization may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule.

**Part A:** Please complete the following information exactly as it appears on your member Identification (ID) Card. If you are a new member and do not yet have a member ID card, please complete as much information as possible. If necessary, please contact your Employee Benefits Administrator, the Broker / Agent servicing your policy, or a BCBSGA Customer Care Associate for assistance.

<i>Member Last Name</i>	<i>Member First Name</i>	<i>Middle Initial</i>	<i>Suffix</i>
<i>Member ID Number (From Member ID Card)</i>	<i>Social Security Number</i>	<i>Date of Birth (mm / dd / yyyy)</i>	<i>Daytime Telephone (with Area Code)</i>
<i>Member Street Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
<i>Employer Group Name</i>	<i>Employer Group Number</i>	<i>Member Home Fax Number (Optional Entry)</i>	
<b><i>If you are covered under another BCBSGA Healthcare Policy, please complete the following blocks. If not applicable, leave blank or enter N/A.</i></b>			
<i>Other Employer Group Name</i>	<i>Other Employer Group Number</i>	<i>Member ID Number (From Other Member ID Card)</i>	

**Part B:** I authorize the following persons, classes of persons or entities, to receive my Protected Health Information (PHI). You should check only those blocks that apply to your needs or situation. Please refer to the instructions if you have any questions.

<input type="checkbox"/> My Spouse (Enter Name)	<input type="checkbox"/> The Agent/Broker or Insurance Agency servicing my policy
<input type="checkbox"/> My Domestic Partner (Enter Name)	<input type="checkbox"/> My Employee Benefits Administrator (applicable <u>only</u> if you are covered by a Group Policy)
<input type="checkbox"/> My Adult Children (Enter Name(s))	<input type="checkbox"/> Other Authorized Representative (Enter Name)
<input type="checkbox"/> My Parents (if you are over 18) (Enter Name(s))	<input type="checkbox"/> Other Authorized Representative (Enter Name)

**Part C:** I authorize the following Protected Health information to be used or disclosed on my behalf. Please check all blocks that apply.

Member ID Number \_\_\_\_\_  
(Enter your Social Security Number if you do not have a member ID Number)

<input type="checkbox"/> All information regarding my health coverage or treatment received ( <i>see instructions</i> )	<input type="checkbox"/> Benefits information
<input type="checkbox"/> All claims and payment information	<input type="checkbox"/> Billing information
<input type="checkbox"/> Appeals information	<input type="checkbox"/> Eligibility and enrollment information
<input type="checkbox"/> Psychotherapy notes ( <i>* refer to the note listed below prior to checking this block</i> )	<input type="checkbox"/> Other (List)

**\* By law, an authorization to release psychotherapy notes cannot be combined with any other authorization. If this authorization is for psychotherapy notes, you must complete a separate authorization for any other type of PHI you want released.**

**Part D:** Purpose of this authorization. *Please check ONLY ONE of the following blocks.*

<input type="checkbox"/> This authorization allows BCBSGA to respond to all requests, questions or transactions involving my health coverage or status received from the persons or entities designated in Part B above.
<input type="checkbox"/> This authorization allows BCBSGA to respond to all requests, questions or transactions involving my health coverage or status received from the persons or entities designated in Part B above for <i>only</i> the following purposes (list):

**Part E:** Expiration Date. (*See instructions*).

This authorization will expire upon the end of my coverage with Blue Cross and Blue Shield of Georgia or on the date specified below.

This authorization will expire on \_\_\_\_\_ (mm, dd, yyyy)

**Part F:** I have read the contents of this authorization and understand and agree to the use and disclosure of my Protected Health Information as specified above. I also understand this authorization is voluntary and that it will not condition my enrollment in a health plan, eligibility for benefits or payment of claims.

\_\_\_\_\_  
(Member Signature) Date: \_\_\_\_\_

### Designated Legal Representative / Guardian

If this form is signed by a legal representative / guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the ability of the legal representative to act on the individual's behalf, must be attached.

Legal representative (print full name): \_\_\_\_\_

Legal relationship to individual: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Your Completed Forms

Completed forms should be faxed or mailed to the address shown below. *This form cannot be submitted by EMAIL.* Failure to provide all necessary information will result in the form being returned to you. If you require assistance, please contact BCBSGA at the number shown on your ID card.

**Please FAX to (404) 842-8040 or mail to Blue Cross Blue Shield of Georgia, ATTN: Membership & Billing Department (Mail Code G00502), P.O. Box 4445, Atlanta, GA 30326**

*Please Keep a Copy of this Authorization Form for your Records*  
A copy will be provided upon your request