

EXHIBIT A

RIGHTS AND OBLIGATIONS

I hereby apply for myself and my eligible family members for (a) the medical coverage specified in the Contract between my Employer and BlueCross and BlueShield of Georgia, Inc., and BlueCross BlueShield Healthcare Plan of Georgia, Inc., (hereinafter referred to as the Company) and (b) if so indicated, life insurance provided by the Group Insurance Contract issued by Greater Georgia Life Insurance Co. to my Employer.

I understand and agree that the effective date of coverage will be governed by the stipulations of the Group Application and the Master Group Contract under which this application is made. I understand that membership will continue according to the terms of the contract between my Employer and the Company. I hereby authorize my Employer to periodically deduct any charge due from me hereunder and to remit same to the Company along with any contribution due from Employer. I understand and agree that the Company reserves the right to change the subscription charges due for this coverage and to increase or decrease the benefits by giving sixty (60) days written notice to my Employer.

I hereby authorize any hospital, physician, psychiatrist, psychologist, counselor, psychiatric hospital or other provider, dispenser of prescription drugs, appliances, ambulance service or any person or any institution rendering services to me or members of my family if covered hereunder, to furnish to the Company and/or Greater Georgia Life Insurance Co. all requested information concerning treatment, advice, psychiatric care or medical care for previous or future conditions, illnesses or disabilities.

I declare that all statements made hereon including the information provided on the front of this application are complete and true to the best of my knowledge and belief, and agree that the Company may cancel this coverage within two (2) years from the effective date, for any ineligible family member or one on whom erroneous or false information has been submitted, personally assuming liability for reimbursement to the Company for any benefit payment made on behalf of such family member. After this contract has been in force for a period of two (2) years during the lifetime of the insured, it shall become incontestable as to the statements in the applications. I understand that I am responsible for giving notice to my Employer of any changes in my status and that of my family members which affect coverage.

CONDITIONAL RECEIPT AND PRIVACY

I declare that all statements and information made hereon are complete and true to the best of my knowledge. I understand that any misstatements or omissions may void all coverage applied for on any member on this application on a retroactive basis for up to two (2) years from the contract effective date. By signing this line, I understand that a pre-existing condition exclusion may apply (except for BlueChoice Healthcare Plan and in-network BlueChoice Option) up to twelve (12) months under the BCBSHP/BCBSGA contract, as defined in the benefit booklet.