Employee Enrollment Application
For 51+ Employee Groups
Georgia

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete electronically, or in blue or black ink only.

Employer name	Group no.	Subsection
CAREER PERSONNEL INC	GA8675	

Section A: Employee Information

Last name	First name	M.I.	Social Security no.* (required)

Birthdate (MM/DD/YYYY)	Home address

City	County	State	ZIP code

Sex	Marital status	Primary phone no.
☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner	

Employee email address

Employment status	Hire date (MM/DD/YYYY)	No. of hours worked per week
☐ Full time ☐ Part time ☐ Disabled ☐ Retired		

PCP name	PCP ID no.	Existing patient
		☐ Yes ☐ No

Section B: Application Type

Select one

☐ New enrollment
☐ Open enrollment
☐ COBRA –
Select qualifying event
☐ Left employment
☐ Loss of dependent child status
☐ Medicare
☐ Reduction in hours
☐ Divorce or legal separation
☐ Covered employee's Medicare entitlement
☐ Death

Qualifying event date

*Blue Cross and Blue Shield of Georgia is required by the Internal Revenue Service to collect this information.

Reset Form Save and Print

Social Security no.* (required)

Section C: Type of Coverage

1. Medical Coverage

Select network: ☐ HMO ☐ PPO ☑ POS

Enter product name: _____

Member medical coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

2. Dental Coverage

Enter product selected: _____

Member dental coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

3. Vision Coverage

Enter product selected: _____

Member vision coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

4. Life and Disability Coverage

If you select Life and/or Disability coverage over the guarantee issue amount or are a late entrant an Evidence of Insurability form may be sent to you to complete.

☐ Basic Life & AD&D ☐ Short-Term Disability ☐ Basic Dependent Life ☐ Long-Term Disability	Life Class
Current income: $ _____ ☐ Hour ☐ Week ☐ Month ☐ Year	Occupation

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above.

NOTICE OF EXCHANGE OF INFORMATION To proposed Insured and other persons proposed to be Insured, if any – information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse consent for designation.)
If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse/Domestic Partner signature	Spouse/Domestic Partner name	Date
X		

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Social Security no.* (required)

Section D: Coverage Information — All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Spouse/Domestic Partner last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No

Dependent last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ____		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No
Does this dependent have a different address? ☐ **Yes** ☐ **No If yes, please enter:** ____					

Dependent last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ____		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No
Does this dependent have a different address? ☐ **Yes** ☐ **No If yes, please enter:** ____					

Dependent last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ____		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No
Does this dependent have a different address? ☐ **Yes** ☐ **No If yes, please enter:** ____					

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Social Security no.* (required)

Section E: Beneficiary — Please note: proceeds are to be designated as a percent when there is more than one primary or one contingent listed. Attach a separate sheet if necessary.

Primary Beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Contingent Beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Section F: Medical Information

1. Has anyone listed on this application ever had medical advice, treatment or do you know, or have reasons to know, of health problems in regard to the following? **Check Yes or No.**
   - a. Cancer, tumor, or neoplasm** ☐ Yes ☐ No
   - b. Organ transplantation ☐ Yes ☐ No
   - c. Disorders of the heart or circulatory system** ☐ Yes ☐ No
   - d. Hepatitis ☐ Yes ☐ No
2. Is anyone listed on this application pregnant? ☐ Yes ☐ No
   If yes, when is the expected due date? ☐☐/☐☐/☐☐☐☐
3. Has any applicant been advised to undergo a surgical operation or procedure within the last six months? ☐ Yes ☐ No
4. Is any applicant currently taking prescription drugs? If yes, please list on a separate sheet and attach. ☐ Yes ☐ No

** If you answered yes, please complete the appropriate health questionnaire. You can download the forms at www.bcbsga.com.

This question MUST be answered for 20–99 employees.

5. Has anyone applying for coverage been treated for a serious illness (For example: cancer, diabetes, heart disease, cardiovascular disease, AIDS or AIDS-related disease, pregnancy, mental/nervous disorder, substance abuse, or any illnesses related to a major body organ) been hospitalized, had surgery, OR incurred healthcare claims in excess of $7,500 in the last 12 months? ☐ Yes ☐ No

This section MUST be completed if you answered "Yes" to any questions 1–5 above.

Person treated	Name of illness or disorder	Type of treatment received	Treatment dates
			From: ☐☐/☐☐/☐☐☐☐ To: ☐☐/☐☐/☐☐☐☐
			From: ☐☐/☐☐/☐☐☐☐ To: ☐☐/☐☐/☐☐☐☐
			From: ☐☐/☐☐/☐☐☐☐ To: ☐☐/☐☐/☐☐☐☐
			From: ☐☐/☐☐/☐☐☐☐ To: ☐☐/☐☐/☐☐☐☐
			From: ☐☐/☐☐/☐☐☐☐ To: ☐☐/☐☐/☐☐☐☐

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Social Security no.* (required)

Section G: Other Group Coverage

Are any applicants eligible for Medicare?
☐ Yes ☐ No

If yes, give name: _____

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply)
			☐ Age ☐ Disability ☐ ESRD: Onset date _____

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date

Are any applicants covered by another health plan?
☐ Yes ☐ No

If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policy holder name	Dates (if applicable)
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:

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Social Security no.* (required)

Section H: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Blue Cross and Blue Shield of Georgia (BCBSGa) as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible dependent:

- Employee's spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

W-9 Certification Language

As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

In signing this application I represent that: I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide BCBSGa with information regarding my HSA. I hereby authorize the financial custodian to provide BCBSGa with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide BCBSGa with a written request to revoke my authorization at any time.

Coverage Option: If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, BCBSGa or by another carrier.

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 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. O.C.G.A. section 33-39-5, subsection (c) (1 through 4) requires that: 1. Personal information may be collected from persons other than the individual or individuals proposed for coverage; 2. Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization; 3. A right of access and correction exists with respect to all personal information collected; 4. The notice prescribed in subsection (b) of the above referenced Code section will be furnished to the applicant or policyholder upon request.

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 practices, please contact Blue Cross and Blue Shield of Georgia, Inc. or Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

☐ BY CHECKING THIS BOX, I AGREE TO RECEIVE ALL MAILINGS AND COMMUNICATIONS ELECTRONICALLY. SUCH ELECTRONIC MAILINGS OR COMMUNICATIONS MAY EVEN INCLUDE CANCELLATION OR NONRENEWAL NOTICES. I will be notified of such electronic communications at the email address I provided on this application or by mail. I understand that I can revoke this authorization at any time free of charge by contacting BCBSHP customer service or online at www.bcbsga.com.

Sign here	Applicant signature **X**	Date (MM/DD/YYYY)

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Social Security no.* (required)

Section I: Waiver/Declining Coverage

Medical Coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's group coverage
- ☐ Enrolled in other Insurance –
  Please provide company name and plan: _____
- ☐ Enrolled in Individual coverage
- ☐ Spouse covered by employer's group medical Coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Dental Coverage

Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's group coverage
- ☐ Enrolled in other Insurance –
  Please provide company name and plan: _____
- ☐ Enrolled in Individual coverage
- ☐ Spouse covered by employer's group medical Coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Vision Coverage

Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's group coverage
- ☐ Enrolled in other Insurance –
  Please provide company name and plan: _____
- ☐ Enrolled in Individual coverage
- ☐ Spouse covered by employer's group medical Coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Life Coverage

***Life** coverage declined for: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Religious reasons
- ☐ Other – please explain: _____
- ☐ No coverage

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Signature required if you are declining coverage.

Signature of applicant	Printed name	Social Security no.	Date (MM/DD/YYYY)
X			

Special Enrollment Rights

If you declined enrollment for yourself or your dependent(s) (including a spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- Either your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

In these cases, you may be able to enroll yourself and your dependents provided that you request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

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