



# Choose Your 65PLUS Plan.

Apply today to secure the health care coverage you deserve.

- 1. Complete all sections of this application.**
- 2. Be sure to sign your name next to the "X".**
- 3. Return your completed and signed application in the postage-paid envelope provided.**

## About you.

**1** First name \_\_\_\_\_ M.I. \_\_\_\_\_ Last name \_\_\_\_\_

**2** Street or Box No. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

**3** Your phone number \_\_\_\_\_ Social Security No. \_\_\_\_\_ Your Medicare number \_\_\_\_\_

**4** Date of birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

## 5 How would you like to be billed?

- Monthly bill  Monthly deduction from checking account

Whichever method of payment you choose, please include a check for the first month's premium made payable to Blue Cross and Blue Shield of Georgia.

## 6 Billing Type

- Credit Card  Monthly Bank Draft - *First month credit or cash required, draft to begin second month.*  
(Note: Complete Bank Draft on page 7)

## 7 Credit Card Information

Type of Card: \_\_\_\_\_ Credit Card Number \_\_\_\_\_ Exp. Date \_\_\_\_\_  
Name as it appears on Credit Card \_\_\_\_\_

## 8 You must be a Georgia resident, have Medicare Parts A & B, and be 65 or older to enroll.

Medicare Part A effective date \_\_\_\_\_ Medicare Part B effective date \_\_\_\_\_

## 9 All plans are guaranteed renewable.

Please indicate which 65PLUS Insurance Plan you wish to apply for by checking the appropriate box.

- Plan A  Plan C  Plan E  Plan F  SmartChoice  SmartChoice Preferred  Plan J

**Please indicate that you wish to apply for the AdvantageCare Rider by checking the box. (You must complete section 12)**

**When would you like your policy to be effective?** \_\_\_\_/\_\_\_\_/\_\_\_\_

(We will need your application by the 25<sup>th</sup> of the month for it to be effective on the 1<sup>st</sup> of the following month.)

**Your Acceptance May be Guaranteed.** If you qualify for Guaranteed Issue coverage (see Guaranteed Issue Guide), please answer the following question:

What situation do you qualify for under Guaranteed Issue? \_\_\_\_\_ (Situation Number)  
Please include a copy of the required documentation with this application.

## Broker/Agent- Complete Section Entirely

DCN		Group #		Effective Date
<input type="text"/>		<input type="text"/>		<input type="text"/>
Rep. #	Cty. Code	Rate Cat. Quoted	Monthly Dues	Rep's Name (Please Print)
			Amt. Received	Rep's Signature

**10 Are you covered by Blue Cross and Blue Shield health insurance now?**  Yes  No

If yes, please give us the details of your plan:

Your Blue Cross and Blue Shield Group # \_\_\_\_\_ Contract # \_\_\_\_\_

The location of your Blue Cross and Blue Shield Plan: \_\_\_\_\_  
City State

**11 To the best of your knowledge:**

- A. Do you have another Medicare Supplement or health insurance policy or certificate in force?  Yes  No  
a. If yes, please give the name of the company: \_\_\_\_\_
- B. Do you intend to replace your current Medicare Supplement policy or health insurance policy with this Blue Cross and Blue Shield of Georgia Plan?  Yes  No
- C. Do you have any other health insurance coverage that provides benefits similar to our Medicare Supplement plan?  Yes  No  
a. If yes, please give the name of the company: \_\_\_\_\_  
b. What kind of policy? \_\_\_\_\_
- D. Are you covered by Medicaid?  Yes  No  
a. If yes, please indicate which program.  Specified Low-Income Medicaid Beneficiaries (SLMB)  
 Qualified Medicaid Beneficiaries (QMB)  
 Other Medicaid Medical Benefits

**12** If you are applying for coverage during open enrollment or during a Guaranteed Issue period, do not complete the following.

If the answer to any of the health questions is yes, you are not eligible for coverage.

- 1. Are you currently hospitalized, or been hospitalized or confined to a skilled nursing facility within the last 2 years, or has confinement been recommended to a bed, hospital, nursing facility, or other care facility?  Yes  No
- 2. Do you need the assistance of a wheelchair, walker, crutches, or prosthetic appliance (such as an artificial leg, or eye, pacemaker or colostomy bag)?  Yes  No
- 3. Within the past 2 years, have you ever been told by a doctor you had, consulted for treatment, sought treatment, received treatment (including drug therapy) or been hospitalized for:
  - A. Insulin dependent diabetes, internal cancer, leukemia, Hodgkin's disease, coronary artery disease, nephritis, kidney/renal failure, chronic kidney disease, kidney/renal dialysis, amputation or joint replacement due to disease, organ transplant (except cornea), AIDS/ARC.  Yes  No
  - B. Alzheimer's disease, senility, dementia, Parkinson's disease, stroke or brain disorder, multiple sclerosis, neuromuscular disorders.  Yes  No
  - C. Heart conditions including but not limited to heart attack, enlarged heart, congestive heart failure, heart valve replacement, open heart surgery or angioplasty, placement of pacemaker, aneurysm.  Yes  No
  - D. Any respiratory condition including but not limited to Chronic Obstructive Pulmonary Disease (COPD), or emphysema (excluding allergies and asthma).  Yes  No
- 4. Within the last 2 years, have you been advised to enter the hospital or to have any surgery that hasn't been performed?  Yes  No





## Instructions for Completing the BCBSGA Conditioned Authorization to Use or Disclose Protected Health Information for Enrollment in a Health Plan

This instruction sheet has been created to assist you in completing the Blue Cross and Blue Shield of Georgia (BCBSGA) "Conditioned Authorization for Use or Disclosure of Protected Health Information for Enrollment in a Health Plan" form. This form is used to authorize BCBSGA, its agents or subsidiaries, to use or disclose your Protected Health Information (PHI) for the purposes stated on the form. These instructions are designed to complement the information and instructions on the actual authorization form.

- General Instructions:
  - ⊖ Each family member over the age of 18 must individually sign (authorize) Blue Cross and Blue Shield of Georgia (BCBSGA) to obtain medical information that may be necessary to support their enrollment in a BCBSGA health care insurance product. This form and instructions are designed to assist in supporting this effort should it be required.
  - ⊖ If you are unsure of how to complete any entry, after reading this form, please ask a BCBSGA Customer Care Associate, your Agent / Broker or the BCBSGA Associate that is assisting with the enrollment process for assistance.
- Specific Instructions:
  - ⊖ Please date the form in the space provided. This date should be the same as entered on your application. In the space to the right of the date, please enter the Social Security Number of the applicant or contract holder.
  - ⊖ For each member over the age of 18, please print the name of the applicant, spouse or dependent on the applicable line on the left-hand side of the form.
  - ⊖ After printing each individual's name, please have each individual sign in the corresponding space on the right-hand side of the form. The signature should be in the same format as that used on your enrollment application.
  - ⊖ In the event more dependents exist than the space provided, please copy the original enrollment form, prior to signature, and repeat the process outlines above. The forms should be labeled, in the upper right- hand corner: Page 1 of 2, Page 2 of 2, etc.
- Legal representative: If your legal representative or guardian completes the form on your behalf, they should sign and date the authorization in the block shown and attach documentation supporting their status as your legal representative (e.g., Health Care Power of Attorney, court order, proof of legal custody or guardian status, etc.).
- Please make a copy of this authorization and retain it in your records. Then include the completed authorization form in your enrollment package or provide it to the Broker / Agent or the BCBSGA Associate that is assisting you with the enrollment process.



## Conditioned Authorization to Use or Disclose Protected Health Information for Enrollment in a Health Plan

*Please print clearly and use only black ink.*

By signing below, I authorize Blue Cross and Blue Shield of Georgia (BCBSGA) to obtain any necessary medical records from any physicians, hospitals and/or any other health care providers concerning my care and the care of any family member listed on my Application. I understand this information will be used to determine whether my listed family members and I are eligible for enrollment in the coverage requested.

I understand that BCBSGA will not process my Application for enrollment unless this Authorization is signed and returned with my Application. This Authorization permits BCBSGA to request from health care providers any additional medical information needed to determine my eligibility for coverage and/or the eligibility of any family members listed on my Application. This Authorization will expire within one (1) year of the date indicated below.

I understand that I may revoke this authorization at any time during the application process by submitting a completed Authorization Revocation Form to BCBSGA. I may request an Authorization Revocation Form by contacting BCBSGA or the Broker / Agent assisting with my enrollment. If I revoke this authorization, I understand that I/we will not be considered by BCBSGA for enrollment in a health plan.

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

\_\_\_\_\_  
*Enter Applicant Social Security Number*

\_\_\_\_\_  
*Printed name of Applicant*

\_\_\_\_\_  
*Signature of Applicant or Applicant's Personal Representative*

\_\_\_\_\_  
*Printed name of Spouse or Dependent Child over age 18 listed on Application*

\_\_\_\_\_  
*Signature of Spouse or Dependent Children over age 18 listed on the Application.\**

\_\_\_\_\_  
*Printed name of Dependent Child over age 18 listed on Application*

\_\_\_\_\_  
*Signature of Dependent Child\**

\_\_\_\_\_  
*Printed name of Dependent Child over age 18 listed on Application*

\_\_\_\_\_  
*Signature of Dependent Child\**

*\*If listed on your application, your spouse and each dependent child over age 18 must sign above.*

### **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: \_\_\_\_\_

*Please Keep A Copy of this Conditioned Authorization Form for your Records*





**BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS**

I hereby authorize **Blue Cross and Blue Shield of Georgia, Inc.** to draw checks, drafts, orders or electronic funds transfer (EFT) upon my account at the:

_____	_____
NAME OF BANK	CHECKING ACCOUNT NUMBER
_____	_____
STREET ADDRESS OF BANK	CITY, STATE, ZIP CODE OF BANK

for the purpose of paying premiums on insurance issued by Blue Cross and Blue Shield of Georgia, Inc.

I understand if any check, draft, order or EFT transmission is returned due to **payment stopped** or **authorization cancelled**, this will be considered as my request to be billed directly.

_____	_____
CONTRACT HOLDER'S NAME	SOCIAL SECURITY NUMBER
_____	_____
CONTRACT HOLDER'S ADDRESS	CITY, STATE AND ZIP CODE
_____	_____
PRINTED SIGNATURE OF ACCOUNT HOLDER	SIGNATURE OF ACCOUNT HOLDER
	DATE

**NOTE: A VOIDED CHECK MUST BE ATTACHED TO THIS APPLICATION.**

First request for bankdraft plan

**Complete entire form and attach a voided check.**

\* Please indicate the contract number assigned by Blue Cross and Blue Shield of Georgia, Inc. in the space provided above.

**INSTRUCTIONS FOR COMPLETING THE BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS**

**Automatic Premium Payment Plan**

**What is it** A special arrangement for payment of premiums automatically each month to relieve you of concern with due dates and the possibilities of having your insurance lapse unintentionally.

**Who can use It** - Bank draft is an extra convenience for you. It is available if you maintain a regular checking account at your bank and make arrangements with your bank to honor automatic checks and electronic fund transfers.

**How it works** - To initiate the bank draft, you must complete the authorizations above.

**INSTRUCTIONS**

- Complete as follows:
  - Fill in the name of your bank, branch number (*if any*) and the city or state in which the bank or the branch is located.
  - Print the name of your account exactly as it appears on your bank statement or check.
  - Include your checking account number. It will usually be found below the signature line of your personal checks.
  - Sign your name exactly as you do on your personal checks. If there is more than one depositor, all should sign.
  - Include the date you signed the authorizations.
- Attach a VOIDED check and this completed form.** Please be sure the sample check is drawn on the same account as will be used for the automatic premium payment plan.
- The coverage provided by this policy may be terminated by you upon thirty (30) days **written** notice.
- Written notice thirty (30) days in advance as stated above in No. 3 is preferred. However, if any check is returned for **payment stopped** or **authorization cancelled**, this will be considered as your request to be billed directly. No further checks will be presented for payment to your bank. If a check is returned for any other reason, you will be notified by Blue Cross and Blue Shield of Georgia of what is required to pay the premium.

INTERNAL USE ONLY

DCN#: _____
BANK #: _____

