BlueCross BlueShield
Healthcare Plan of Georgia

Primary applicant name: _____

Welcome

Georgia Individual Application

Thanks for choosing us. We're glad you're here.

If you have any questions while filling out this form, give us a call at 1 (877) 206-0913. But if you've worked with an agent or broker, contact them first.

About this form

Use this form to apply for **new** medical, dental or vision coverage or to **change** existing coverage with Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSHP).

You can apply or change coverage:

1. **During the annual Open Enrollment period**
   The earliest your coverage can start is the 1st of the year. Your coverage will start based on when we receive your complete application (including payment). If we get it:
   - Between the 1st and 15th day of the month, coverage is effective the 1st day of the following month.
   - Between the 16th and last day of the month, coverage is effective the 1st day of the second following month.
2. **Due to a qualifying event** (such as getting married, having a baby, etc.)
   When you're done with this form, fill out **Appendix A: Special Enrollment,** which includes information about when coverage starts.
3. **Any time** (for new dental coverage)
   You can apply for new dental coverage any time during the year.

Tips when filling out this form

1. Answer all questions. Please print clearly using blue or black ink only.
2. You can also apply online at **bcbsga.com**.
3. Refer to your Health Plan Guide for plan and enrollment details. Don't have a copy? Ask your agent or contact us.
4. If you're enrolling in an HMO plan, you may need to choose a Primary Care Physician (PCP). View a list of doctors for your plan on anthem.com or call us. If you don't choose a PCP and it's required for your plan, we'll pick one close to you.

Some Frequently asked questions

1. **Do I need to include a payment?**
   Yes. If applying for new coverage, we can't complete your application without your first month's premium payment. Without it, your enrollment will be delayed. Don't worry though – we won't charge your card or cash your check until you've been enrolled.
   If you're already a member, we need your payment before the requested effective date for your change.
2. **What if I already have coverage with another company?**
   Don't cancel your other coverage yet – your health coverage is too important. We'll contact you when you're approved.
3. **Why do you need my Social Security Number?**
   The IRS requires us to collect it. It won't be shared unless required by law. If you enroll in a health savings account (HSA) compatible plan with us, we'll give it to our HSA banking partner.

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Step 1: Who is applying?

Primary Applicant ☐ New coverage ☐ Change coverage ☐ Add dependent to existing coverage ID No. _____

Last Name (Legal Name)	**First Name** (Legal Name)	**M.I.**	**Social Security Number**

Marital status ☐ Single ☐ Married	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)	**Legal resident of GA:** ☐ Y ☐ N **US Citizen or National:** ☐ Y ☐ N	**County** (for home address)	**Tobacco use*** ☐ Yes ☐ No

Home address	**City**	**State**	**ZIP**
Billing address (optional - if different than your home)	**City**	**State**	**ZIP**
Mailing address (optional - if different than your home)	**City**	**State**	**ZIP**

Primary phone	**Secondary phone**	**Email address**

Preferred written language ☐ English (ENG) ☐ Spanish (SPA)	**Preferred spoken language** ☐ English (ENG) ☐ Spanish (SPA)

Primary Care Physician (PCP) (Guided Access HMO Plans only)	**PCP ID**	**Current patient** ☐ Yes ☐ No

Spouse or Domestic partner

Last Name (Legal Name)	**First Name** (Legal Name)	**M.I.**	**Social Security Number**

Relationship to applicant ☐ Spouse ☐ Domestic partner	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)	**Legal resident of GA** ☐ Yes ☐ No	**US Citizen or National** ☐ Yes ☐ No	**Tobacco use*** ☐ Yes ☐ No

Primary Care Physician (PCP) (Guided Access HMO Plans only)	**PCP ID**	**Current patient** ☐ Yes ☐ No

Child dependent Children must be under age 26.

Last Name (Legal Name)	**First Name** (Legal Name)	**M.I.**	**Social Security Number**

Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)	**Legal resident of GA** ☐ Yes ☐ No	**US Citizen or National** ☐ Yes ☐ No	**Tobacco use*** ☐ Yes ☐ No

Primary Care Physician (PCP) (Guided Access HMO Plans only)	**PCP ID**	**Current patient** ☐ Yes ☐ No

Child dependent

Last Name (Legal Name)	**First Name** (Legal Name)	**M.I.**	**Social Security Number**

Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)	**Legal resident of GA** ☐ Yes ☐ No	**US Citizen or National** ☐ Yes ☐ No	**Tobacco use*** ☐ Yes ☐ No

Primary Care Physician (PCP) (Guided Access HMO Plans only)	**PCP ID**	**Current patient** ☐ Yes ☐ No

*Tobacco use is the use of tobacco products 4 or more times per week, on average, in the last 6 months (excluding religious or ceremonial reasons).

Child dependent ☐ **Check here if you have more dependents**. Print an extra copy of this page and attach to your application.

Last Name (Legal Name)	**First Name** (Legal Name)	**M.I.**	**Social Security Number**

Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)	**Legal resident of GA** ☐ Yes ☐ No	**US Citizen or National** ☐ Yes ☐ No	**Tobacco use*** ☐ Yes ☐ No

Primary Care Physician (PCP) (Guided Access HMO Plans only)	**PCP ID**	**Current patient** ☐ Yes ☐ No

*Tobacco use is the use of tobacco products 4 or more times per week, on average, in the last 6 months (excluding religious or ceremonial reasons).

Eligibility

Are any applicants eligible for Medicare?
☐ No ☐ Yes **If yes, who?**

Are any applicants currently incarcerated (with more than 60 days left to serve before release) as a result of a conviction? (not just pending disposition of charges)
☐ No ☐ Yes **If yes, who?**

Are any applicants currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits?
☐ No ☐ Yes **If yes,** fill out the boxes below.

Who	**Reason**	**Start date of benefits**	**End date of benefits**

Step 2: What coverage would you like?

Medical Plans

Please select only one medical plan from the below Blue OpenAccess POS and Pathway Guided Access HMO plans only if you reside in one of the following 10 counties: Bibb, Chatham, Clayton, DeKalb, Fulton, Gwinnett, Henry, Houston, Muscogee, and Richmond.
* These plans require the selection of a Primary Care Physician (PCP).

BCBSHP Bronze

Blue OpenAccess POS]
☐ 10% for HSA (1G70)
☐ 30% for HSA (1G6X)
☐ 5500 (1G6Y)
☐ 6250 (1G6Z)
Pathway Guided Access HMO
☐ 0% for HSA (2J32) *
☐ 30% for HSA (2J3B) *
☐ 5200 (2J4A) *
☐ 5500 (2J4D) *
☐ 5850 (2J3F) *

BCBSHP Silver

Blue OpenAccess POS
☐ 10% for HSA (1G72)
☐ 2250 (1G71)
☐ 3500/10% (1G73)
☐ 3500/25% (1G74)
Core Pathway Guided Access HMO
☐ 5300 (2J47) *
Pathway Guided Access HMO
☐ 10% for HSA (2J38) *
☐ 2000/20% (2J4P) *
☐ 2000/25% (2J3P) *
☐ 3000 (2J4M) *
☐ 3500 (2J40) *

BCBSHP Gold

Blue OpenAccess POS
☐ 1750 (1X57)
Pathway Guided Access HMO
☐ 1150 (2J4N) *

BCBSHP Catastrophic — Only available to applicants under age 30, unless otherwise qualified.

Pathway Guided Access HMO
☐ 7150 (2J4F) *

Please select only one medical plan from the below Blue OpenAccess POS and Pathway HMO plans if you reside in a Georgia county not listed above.

BCBSHP Bronze	BCBSHP Silver	BCBSHP Gold
Blue OpenAccess POS ☐ 10% for HSA (1G70) ☐ 30% for HSA (1G6X) ☐ 5500 (1G6Y) ☐ 6250 (1G6Z) **Pathway HMO** ☐ 0% for HSA (1G5D) ☐ 30% for HSA (1G6F) ☐ 5200 (1G5K) ☐ 5500 (1G6J) ☐ 5850 (2J3C)	**Blue OpenAccess POS** ☐ 10% for HSA (1G72) ☐ 2250 (1G71) ☐ 3500/10% (1G73) ☐ 3500/25% (1G74) **Core Pathway HMO** ☐ 5300 (2J3V) **Pathway HMO** ☐ 10% for HSA (1G5X) ☐ 2000/20% (1G69) ☐ 2000/25% (1G6Q) ☐ 3000 (1G63) ☐ 3500 (1G6V)	**Blue OpenAccess POS** ☐ 1750 (1X57) **Pathway HMO** ☐ 1150 (1G6C) **BCBSHP Catastrophic** — Only available to applicants under age 30, unless otherwise qualified. **Pathway HMO** ☐ 7150 (1G5A)

Health Savings Account (HSA) Enrollment — If you chose an HSA compatible plan, you have the option to setup a health savings account.

☐ Yes, I'd like to establish an HSA with Anthem's banking partner. (Please make sure you entered Social Security numbers in Step 1)

Current (existing) medical coverage

If you already have health care coverage, please don't cancel it until you are effective with us.

☐ One or more of the applicants currently have health care coverage (Please fill out the info below)

People with coverage (Write ALL if everyone)	**Existing health care coverage company**	**Effective date** (When coverage started)
Type of coverage ☐ Group ☐ Individual	**ID number(s)**	**Last date of coverage** (If applicable)

Dental Plans

Dental coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits).
Choose a dental plan and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Dental plan options

☐ BCBSGA Dental Family Value (2J5U)
☐ BCBSGA Dental Family (1FS1)
☐ BCBSGA Dental Family Enhanced (1FS2)
☐ Prime Plan A (1RBG)
☐ Prime Plan B (1RBH)
☐ Prime Plan C (1RBJ)

Existing dental coverage — It's important we know.

☐ I currently have dental coverage (please fill out the info below)

People with coverage (write ALL if everyone applying):

Existing dental coverage company:	**Effective date** (when this coverage started)
ID Number:	**Last date of coverage** (if applicable)

Applicants for dental plan — Check all that apply (Primary applicant must be included)

☐ Primary applicant ☐ Spouse or domestic partner ☐ All dependent children

Vision Plan

You must enroll in medical and/or dental coverage to be eligible for vision coverage.

Vision coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits).
Choose a vision plan and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Vision plan option	**Applicants for vision plan** — Check all that apply (Primary applicant must be included)
☐ Blue View Vision Individual (1RYE)	☐ Primary applicant ☐ Spouse or domestic partner ☐ All dependent children

Step 3: Please read and sign

Important legal information

- I must send my first (initial) premium with this application, but it does not mean coverage has been approved. I'm applying for the coverage I chose on this form. To the extent permitted by law, Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSHP) has the right to accept or decline this application, and that there are no guarantees of any kind just because I filled out this form. If my application is denied, my bank account or credit card will not be charged.
- I'm responsible to let BCBSHP know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- BCBSHP may change check payments to electronic Automated Clearinghouse (ACH) debit transactions. If this happens, my original check will be destroyed. This charge will appear on my bank statement but my check won't be given to my financial institution or sent back to me. This charge will not enroll me in any BCBSHP automatic debit process and will only occur each time I send a check to BCBSHP. Any resubmissions due to insufficient funds may also occur electronically. All checking transactions will remain secure, and my payment by check means I agree to these terms.
- I agree and consent to the recording and/or monitoring of any telephone conversation between BCBSHP and myself.
- I'm applying for individual health and/or dental and/or vision coverage which is not part of any employer sponsored plan. I certify that neither I nor any dependent is being reimbursed or compensated for this coverage by any employer. I'm responsible for all of the premium payments and making sure that all premiums are paid.
- By signing below, I (primary applicant) AGREE TO RECEIVE ALL MAILINGS AND COMMUNICATIONS ELECTRONICALLY. SUCH ELECTRONIC MAILING OR COMMUNICATIONS MAY EVEN INCLUDE CANCELLATION OR NONRENEWAL NOTICES. This may include my contract, evidence of coverage, billing and explanation of benefits, or helpful information to get the most out of my plan. I agree to provide and update BCBSHP with my current e-mail address. I know that at any time I can change my mind and request a free copy of these materials by mail, by contacting BCBSHP.
- I certify that each Social Security number listed on this application is correct.
- My domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is at least 18 years of age; he or she is mentally competent; he or she is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
- I acknowledge that I have read the Important Legal Information section, and I agree to the coverage conditions. I state that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by BCBSHP in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).

I give this authorization for and on behalf of any eligible dependents and myself if covered by BCBSHP. I am acting as their agent and representative.
This application cannot be altered by the applicant after submission to BCBSHP absent the acknowledgement and consent of BCBSHP.

I hereby acknowledge that BCBSHP has informed me of the following prior to my enrollment in their health care coverage plan:

- Number, mix and location of participating/network health care providers;
- Limitations of choices of participation/network health care providers;
- Disclosure of contractual relationship between participation/network provider and BCBSHP.

Please sign below

	Primary applicant (or legal representative)	Date
	Spouse / Domestic Partner (or legal representative)	Date
	Dependent Child (age 18 or over)	Date
	Dependent Child (age 18 or over)	Date
	Dependent Child (age 18 or over)	Date

Did an agent help you? Make sure they fill out this section.

Agent (or broker) Certification	I certify to the best of my knowledge, the responses herein are accurate.			
Agent/Broker Signature				**Date**
Agent Name (Please print clearly) Holly Conley	**Agent TIN / SSN** (Encrypted TIN is ok) 7036459	**Agency or Parent TIN/ID**		
Agent Address 2472 Jett Ferry Rd., # 400-350		**City** Atlanta	**State** GA	**ZIP** 30338
Agent Phone Number 7703969517	**Agent Fax Number** 7703964318	**Agent Email** holly@insurance-now.com		

Thank you! Here's what's next.

1) Can you check a few items? When incorrect, they're the most frequent reasons for delays in enrollment.
   - Your name and address information should be clear and readable
   - You've included your first month's premium payment
   - Everyone 18 and older signed this form
   - If enrolling due to a qualifying event, you've completed Appendix A: Special Enrollment

2) All good? Send this to us by mail to Blue Cross Blue Shield Healthcare Plan of Georgia, PO BOX 659806, SAN ANTONIO, TX 78265-9106 or by fax to 1 (800) 848-2512.

3) We'll be in touch in the next few weeks. If you have questions before then, call us at 1 (855) 837-8540.

We look forward to guiding you on your health care coverage journey.

Appendix A: Special Enrollment

If you're applying for coverage due to a qualifying event, please fill out this section along with your application.

Qualifying event date	
Date of qualifying event	For Loss of Coverage, this is the last date of existing or prior coverage. For all other events, please enter the date based on the qualifying event.

You must apply for coverage within 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
☐ **1. Marriage or Domestic Partnership** Got married or in a domestic partnership that becomes eligible for coverage (see step 3 for description of eligibility)	First day of the month after we receive your complete application.
☐ **2. Birth or Adoption** Had a baby, adoption of a child or placement of a child with you for adoption	**Select an effective date:** ☐ Same as the event date ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application* ☐ First day of month after the event date
☐ **3. Court Order or Guardianship** Required by a court order to provide an eligible child(ren) coverage, including a child support order or appointment of guardianship of a child	**Select an effective date:** ☐ Same as the event date ☐ Based on when we receive your complete application*
☐ **4. Death** Death of a family member enrolled under current coverage	**Select an effective date:** ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application*
☐ **5. Immigration** Immigration status changed ☐ **6. Other qualifying event** If you can't find your situation, contact your agent/broker or call us. We can only enroll based on events defined by state and/or federal law.	Based on when we receive your complete application*

You must apply for coverage within 60 days before or 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
7. Loss of coverage: Lost or will lose Minimum Essential Coverage: ☐ Involuntary loss of coverage (for any reason except non-payment of premium or fraud) ☐ A legal separation or divorce ☐ Moved to a new service area, Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move.	First day of the month after we receive your complete application.
☐ **8. Permanent Move** Moved to U.S. from a foreign country or a U.S. territory ☐ **9. Non-calendar renewal** Current policy does not renew on a calendar year basis (renews on a date other than January 1) ☐ **10. Jail or prison** Released from jail or prison (incarceration)	Based on when we receive your complete application*

* If the coverage date is based on when we receive your application, then if we receive it:
- Between the 1st and 15th day of the month, coverage is effective the 1st day of the following month.
- Between the 16th and the last day of the month, coverage is effective the 1st day of the second following month.

Almost there! We need a bit more info.

We need supporting documentation for your qualifying event, such as a letter or official form from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected. If you're applying because you've lost your coverage, we need to know the reason why coverage was lost, and it must be included in the supporting documentation. In all instances, we might need additional documentation to confirm eligibility.

Give us or your agent a call if you have any questions.

Appendix B: Employee Affidavit

Conditional Receipt

THIS RECEIPT DOES NOT PROVIDE ANY COVERAGE UNTIL ALL THE TERMS AND CONDITIONS LISTED BELOW ARE MET.

BCBSHP has received from the named Applicant an initial payment equal to the first month's premium together with an application for designated health insurance coverage. Such payment is accepted subject to the following conditions:

Subject to the provisions of the contract, the coverage applied for will be effective from, and the contract date as of, the day following acceptance by BCBSHP, unless otherwise specifically stated, provided that the payment evidenced by this receipt is the full first month's dues and provided that BCBSHP determines that as of the date of the application all proposed covered persons were acceptable for coverage and for the benefits applied for. If the application is not approved by BCBSHP said Plan shall incur no liability and the payment evidenced by this receipt will be refunded to the applicant. No one has the authority to waive or modify any of the terms or conditions of this receipt.

If you do not receive a contract within 60 days, please contact Blue Cross Blue Shield Healthcare Plan of Georgia Customer Service at (855) 402-9635 or P.O. Box 105370, Atlanta, GA 30348-5370.

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 need your answers to decide if you qualify for coverage. 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. Official Code of Georgia, Code 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; and
4. The notice prescribed in subsection (c) 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 Blue Shield Healthcare Plan of Georgia Customer Service at (855) 402-9635 or P.O. Box 105370, Atlanta, GA 30348-5370.

Payment Methods for Individual Applications – Georgia

BlueCross BlueShield Healthcare Plan of Georgia

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Automatic Premium Payment (complete Section A)

☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account

☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)

Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize BlueCross BlueShield Healthcare Plan of Georgia to pay and charge to my account checks drawn on that account by and made payable to the order of BlueCross BlueShield Healthcare Plan of Georgia, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by BlueCross BlueShield Healthcare Plan of Georgia of which I am notified pursuant to my plan/policy. I agree that BlueCross BlueShield Healthcare Plan of Georgia's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize BlueCross BlueShield Healthcare Plan of Georgia to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing BlueCross BlueShield Healthcare Plan of Georgia a 30-day written notice. I agree that BlueCross BlueShield Healthcare Plan of Georgia shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, BlueCross BlueShield Healthcare Plan of Georgia shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should BlueCross BlueShield Healthcare Plan of Georgia's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize BlueCross BlueShield Healthcare Plan of Georgia to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by BlueCross BlueShield Healthcare Plan of Georgia of which I am notified pursuant to my plan/policy. I agree that BlueCross BlueShield Healthcare Plan of Georgia shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, BlueCross BlueShield Healthcare Plan of Georgia shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. BlueCross BlueShield Healthcare Plan of Georgia **accepts Visa ☐ and MasterCard ☐.**

Card Number:	Expiration Date:	
Billing address for this Credit / Debit Card:	**City:**	**Zip Code:**

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize BlueCross BlueShield Healthcare Plan of Georgia either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When BlueCross BlueShield Healthcare Plan of Georgia uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.

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