

GEORGIA BANKERS ASSOCIATION INSURANCE TRUST, INC.

PART TIME ENROLLMENT CARD

Please use black ink. Incomplete forms could delay coverage and insurance ID cards

EMPLOYEE SOCIAL SECURITY NUMBER

____ - ____ - _____

GENDER

M F

MARITAL STATUS

S M D

EMPLOYEE NAME - FIRST

MI

LAST

EMPLOYEE HOME ADDRESS - STREET

CITY

STATE

ZIP

COUNTY

EMPLOYER (COMPANY) NAME

EMPLOYER CITY

BANK NUMBER

DATE OF BIRTH (MM-DD-YYYY)

____ - ____ - _____

DATE EMPLOYED

____ - ____ - _____

DATE FULL - TIME STATUS

____ - ____ - _____

ANNUAL BASE EARNINGS

EMPLOYEE PRIMARY CARE PHYSICIAN (PCP) - FOR HMO OR POS ONLY

PCP ID #

_____ - _____

EXISTING PATIENT ?

Y N

ELIGIBLE FIRST OF THE MONTH FOLLOWING DATE OF FULL-TIME EMPLOYMENT OR AFTER EMPLOYER'S WAITING PERIOD IF APPLICABLE MINIMUM 30 HOURS REQUIRED

LIFE INSURANCE BENEFICIARY			RELATIONSHIP AND SOCIAL SECURITY NUMBER
FIRST NAME	MIDDLE INITIAL	LAST	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IMPORTANT - CHECK COVERAGES DESIRED

EMPLOYEE LIFE INSURANCE PLAN # _____

DEPENDENT LIFE - CHOOSE ONE: BASIC \$2,000 OR TOTAL OF \$10,000

PART - TIME EMPLOYEES ARE NOT ELIGIBLE FOR LONG TERM DISABILITY COVERAGE

DENTAL PLAN # _____ EMPLOYEE ONLY EMP. / SPOUSE EMP. / CHILDREN EMP. / SPOUSE / CHILDREN

MEDICAL PLAN - CHOOSE ONE: PPO PLAN # _____ HMO PLAN # 600 POLICY # 1002806-000 POS # 260
 HMO PLAN # 610 POLICY # 1002806-001 HMO PLAN # 620 POLICY # 1002806-002 POLICY # 1002806 100

CHOOSE COVERAGE LEVEL: EMPLOYEE ONLY EMP. / SPOUSE EMP. / CHILDREN EMP. / SPOUSE / CHILDREN

DECLINING COVERAGE FOR EMPLOYEE AND/OR DEPENDENTS - If you are declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the qualifying event.

Declined health coverage for:	Employee	Spouse	Children	Reason declined	other coverage	other reason _____
Declined dental coverage for:	Employee	Spouse	Children	Reason declined	other coverage	other reason _____

DEPENDENTS APPLYING FOR MEDICAL AND/OR DENTAL COVERAGE

NOTE : PCP (PRIMARY CARE PHYSICIAN) INFORMATION NEEDED ONLY IF SELECTING HMO / POS HEALTH PLANS

SPOUSE	<input type="checkbox"/> M	LAST NAME	DATE OF BIRTH (MM-DD-YYYY)	PCP NAME	EXISTING PATIENT ?
		____	____ - ____ - _____	_____	<input type="checkbox"/>
	<input type="checkbox"/> F	FIRST NAME	SOCIAL SECURITY NUMBER	PCP ID #	
		____	____ - ____ - _____	_____	
CHILD 1	<input type="checkbox"/> M	LAST NAME	DATE OF BIRTH (MM-DD-YYYY)	PCP NAME	EXISTING PATIENT ?
		____	____ - ____ - _____	_____	<input type="checkbox"/>
	<input type="checkbox"/> F	FIRST NAME	SOCIAL SECURITY NUMBER	PCP ID #	
		____	____ - ____ - _____	_____	
Disabled ?		<input type="checkbox"/> Y <input type="checkbox"/> N	College Student?	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of College: _____
					Grad. Date: _____

CHILD 2	M	LAST NAME	DATE OF BIRTH (MM-DD-YYYY)	PCP NAME	EXISTING PATIENT ?
	F	FIRST NAME	SOCIAL SECURITY NUMBER	PCP ID #	
		Disabled ? <input type="checkbox"/> Y <input type="checkbox"/> N	College Student? <input type="checkbox"/> Y <input type="checkbox"/> N	Name of College: _____	
				Grad. Date: _____	
CHILD 3	M	LAST NAME	DATE OF BIRTH (MM-DD-YYYY)	PCP NAME	EXISTING PATIENT ?
	F	FIRST NAME	SOCIAL SECURITY NUMBER	PCP ID #	
		Disabled ? <input type="checkbox"/> Y <input type="checkbox"/> N	College Student? <input type="checkbox"/> Y <input type="checkbox"/> N	Name of College: _____	
				Grad. Date: _____	
CHILD 4	M	LAST NAME	DATE OF BIRTH (MM-DD-YYYY)	PCP NAME	EXISTING PATIENT ?
	F	FIRST NAME	SOCIAL SECURITY NUMBER	PCP ID #	
		Disabled ? <input type="checkbox"/> Y <input type="checkbox"/> N	College Student? <input type="checkbox"/> Y <input type="checkbox"/> N	Name of College: _____	
				Grad. Date: _____	

OTHER COVERAGE INFORMATION - COMPLETE IF ENROLLING IN MEDICAL AND/OR DENTAL COVERAGE

After this coverage begins, will you or any members of your family be covered under another group's insurance plan? Y N

If yes, please complete the information below. If no, please skip this section.

NAME AND DATE OF BIRTH OF INSURED _____

NAME OF INSURANCE CARRIER _____

ADDRESS OF INSURANCE CARRIER _____

INSURANCE POLICY NUMBER _____

Type of Plan Medical Dental Both

Type of Coverage Family Individual Only

Does this plan coordinate by Gender or Birthday rule? _____

If there is family coverage, please list family members covered under this plan:

SB476 ACKNOWLEDGEMENT

I understand that I am enrolling in a health care plan, which requires that health care services must be provided by participating providers. Failure to use a participating provider will result in reduced coverage or no coverage for services that I receive, and I will be fully responsible for any and all costs not covered by Blue Cross and Blue Shield of Georgia/Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSGA) (as applicable).

I have received a complete listing of participating providers. I understand that the participation status of any provider may change from time to time. It is my responsibility to verify that my health care provider is participating with BCBSGA/BCBSHP prior to receiving services. I may verify participation status via BCBSGA's Web site, www.bcbsga.com which is updated at least every 30 days. I may also verify status by contacting the customer service number listed on my member ID card.

As required by the State of Georgia regulations, the following is a summary of the financial arrangements with the health care providers who are participating in the BCBSGA/BCBSHP network:

1. Hospital providers are paid according to a contract which includes inpatient per diems, case rates, and discounted fee for service arrangements depending on specific services provided.
2. Physicians are paid discounted fee for service in accordance with a specific fee schedule, which has been provided to them as contracted.
3. Laboratory services are provided through a capitated per member per month flat fee.
4. Other ancillary services including home health, skilled nursing, and hospice are paid on a contracted fee schedule with per diems or per visit amounts.

By signing below, I acknowledge my understanding of these plan provisions and am enrolling in the coverages accordingly. I also certify that all the information on this form, including dependent information and other coverage information is accurate.

Signature

Date