



CHILD 2	M	LAST NAME	DATE OF BIRTH (MM-DD-YYYY)
	F	FIRST NAME MI	SOCIAL SECURITY NUMBER
	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)
	F	FIRST NAME MI	SOCIAL SECURITY NUMBER
	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)
	F	FIRST NAME MI	SOCIAL SECURITY NUMBER
	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