

I HEREBY AUTHORIZE AND REQUEST THAT THE FOLLOWING CHANGES IN CONNECTION WITH MY GROUP INSURANCE BE MADE

EMPLOYER NAME _____

EMPLOYER CITY _____

EMPLOYEE NAME _____

EMPLOYEE ADDRESS (STREET, CITY, STATE, ZIP CODE) _____

SOCIAL SECURITY NO. _____

PLEASE CHECK ITEMS TO BE CHANGED

EMPLOYEE STATUS

- Name Change
- Add Employee Medical Coverage
- Terminate Employee Medical Coverage
- Add Employee Dental Coverage
- Terminate Employee Dental Coverage
- Change Address
- Termination of Employment Date _____
- Reason for Termination Involuntary
- Voluntary

BENEFICIARY STATUS

- Beneficiary
- Name of Beneficiary
- Relationship of Beneficiary

DEPENDENT STATUS

- Add Dependent Medical
 - Terminate Dependent Medical
 - Add Dependent Dental
 - Terminate Dependent Dental
 - Add a Dependent(s)
 - Delete a Dependent(s)
- List Dependents on Reverse Side**

DEPENDENT LIFE STATUS

- Add Basic 2000 Dependent Life*
 - Terminate Basic 2000 Dependent Life
 - Add Optional 8000 Dependent Life*
 - Terminate Optional 8000 Dependent Life
- *If dependent life was not applied for within 31 days of eligibility, complete a medical questionnaire form for underwriting

Reason for Change Loss of Spousal Employment Divorce Marriage Birth Legal Adoption Other _____

Date of change for the above reason _____

CHANGE BENEFICIARY

TO _____	SOCIAL SECURITY NO.	RELATIONSHIP

CHANGE IN EMPLOYEE'S NAME

FROM _____	DATE OF MARRIAGE	DATE OF DIVORCE
TO _____		

SIGNATURE OF EMPLOYEE _____

DATE SIGNED _____

OTHER COVERAGE INFORMATION
(Complete and sign if adding medical/dental coverage)

Are you or any members of your family covered under another group's insurance plan? Yes No

If yes, please complete the information below. If no, please skip this section and sign at the bottom.

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 the plan:

SIGNATURE _____

DATE _____

LIST DEPENDENTS TO BE COVERED

LIST COLLEGE STUDENT DEPENDENTS AGE 19 - 26

PLEASE SUBMIT A COPY OF STUDENT ENROLLMENT INFORMATION. CLASS SCHEDULE WITH DATE IS ACCEPTABLE.

NAME	RELATIONSHIP / SEX <small>CIRCLE ONE</small>	SOCIAL SECURITY NO.	DATE OF BIRTH
_____	Spouse F / M	_____	_____
_____	Child F / M	_____	_____
_____	Child F / M	_____	_____
_____	Child F / M	_____	_____
_____	Child F / M	_____	_____
_____	Child F / M	_____	_____

LIST DEPENDENTS TO BE DELETED

NAME	RELATIONSHIP / SEX	SOCIAL SECURITY NO.	DATE OF BIRTH
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SB476 ACKNOWLEDGEMENT (Read and sign if adding medical coverage)

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 the 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 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.

SIGNATURE OF EMPLOYEE _____ DATE SIGNED _____