GBA | INSURANCE TRUST

REQUEST FOR CHANGE

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

EMPLOYER NAME | EMPLOYER CITY | EMPLOYEE SOCIAL SECURITY NUMBER

EMPLOYEE NAME | EMPLOYEE STREET ADDRESS | EMPLOYEE CITY, STATE, ZIP

PLEASE CHECK ITEMS TO BE CHANGED

EMPLOYEE STATUS

- ☐ Name Change
- ☐ Add Employee Medical Coverage
- ☐ Term Employee Medical Coverage
- ☐ Add Employee Dental Coverage
- ☐ Term Employee Dental Coverage
- ☐ Change Address
- ☐ Termination of Employment

Date _____

- ☐ Involuntary
- ☐ Voluntary

BENEFICIARY STATUS

- ☐ Beneficiary
- ☐ Name of Beneficiary
- ☐ Beneficiary Relationship

DEPENDENT STATUS

- ☐ Add Dependent Medical
- ☐ Term Dependent Medical
- ☐ Add Dependent Dental
- ☐ Term Dependent Dental
- ☐ Add a Dependent(s)
- ☐ Delete a Dependent(s)

DEPENDENT LIFE STATUS

- ☐ Add Basic 2000 Dependent Life*
- ☐ Term Basic 2000 Dependent Life
- ☐ Add Optional 8000 Dependent Life*
- ☐ Term Optional 8000 Dependent Life

*If dependent life was not applied within 31 days of eligibility, complete a medical questionnaire form for underwritting

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

Date of change for the above reason(s) : _____ (MM/DD/YYYY)

CHANGE BENEFICIARY	SOCIAL SECURITY NUMBER	RELATIONSHIP
TO:		

CHANGE IN EMPLOYEE'S NAME	DATE OF MARRIAGE	DATE OF DIVORCE
FROM:		
TO:		

Signature of Employee _____ *Date Signed* _____

OTHER COVERAGE INFORMATION

(complete & 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 INAURANCE 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 OF 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	SOCIAL SECURITY NUMBER	DATE OF BIRTH
	Spouse	☐ Female ☐ Male		
	Child	☐ Female ☐ Male		
	Child	☐ Female ☐ Male		
	Child	☐ Female ☐ Male		
	Child	☐ Female ☐ Male		
	Child	☐ Female ☐ Male		

LIST DEPENDENTS TO BE DELETED

NAME	RELATIONSHIP	SEX	SOCIAL SECURITY NUMBER	DATE OF BIRTH
	Spouse	☐ Female ☐ Male		
	Child	☐ Female ☐ Male		
	Child	☐ Female ☐ Male		
	Child	☐ Female ☐ Male		

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 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 status via BCBSGA's Web site, wwww.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 pre diems, case rates, and discounted fees for services 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* _____