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

ELIGIBLE FIRST OF THE MONTH FOLLOWING 6 MONTHS OF REGULAR PART-TIME EMPLOYMENT

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**

☐ **DENTAL PLAN #**   ☐ **EMPLOYEE ONLY** ☐ **EMP. / SPOUSE** ☐ **EMP. / CHILDREN** ☐ **EMP. / SPOUSE / CHILDREN**

☐ **MEDICAL PLAN - CHOOSE ONE:**   ☐ **HMO PLAN #** ☐☐☐   ☐ **POS PLAN #** ☐☐☐   ☐ **PPO PLAN #** ☐☐☐

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

DECLINING HEALTH COVERAGE FOR EMPLOYEE AND/OR DEPENDENTS - If you are declining enrollment for yourself or your dependents (including your spouse) because of other health 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

		LAST NAME	DATE OF BIRTH (MM-DD-YYYY)
SPOUSE	M		
		FIRST NAME MI	SOCIAL SECURITY NUMBER
	F		
CHILD 1	M	LAST NAME	DATE OF BIRTH (MM-DD-YYYY)
		FIRST NAME MI	SOCIAL SECURITY NUMBER
	F		
	Disabled ? ☐ Y ☐ N		

		LAST NAME		DATE OF BIRTH (MM-DD-YYYY)
CHILD 2	M			☐☐-☐☐-☐☐☐☐

CHILD 2

M LAST NAME

F FIRST NAME   MI   SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM-DD-YYYY)

Disabled ? ☐ Y ☐ N

CHILD 3

M LAST NAME

F FIRST NAME   MI   SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM-DD-YYYY)

Disabled ? ☐ Y ☐ N

CHILD 4

M LAST NAME

F FIRST NAME   MI   SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM-DD-YYYY)

Disabled ? ☐ Y ☐ N

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**