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 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 OF DEPENDENTS TO BE COVERED

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* ______________