

**Use this checklist to make sure you  
have included all that is required.**

- \_\_\_\_\_ 1. **One application if applying for family plan with maternity or 2 separate applications if applying for 2 people that do not need maternity (this gives you the most inexpensive premium). **IMPORTANT: The oldest person listed on the application must be listed as the primary applicant.****
- \_\_\_\_\_ 2. **First month's premium for each application. If applying for dental, please include an additional \$27 per person or \$76 per family. Premium is based upon the oldest applicant's age (check made payable to Blue Cross)**
- \_\_\_\_\_ 3. **Completed bank draft agreement and voided check (only if paying by automatic bank withdrawal)**
- \_\_\_\_\_ 4. **All adult applicants must sign and date the application**
- \_\_\_\_\_ 5. **The conditioned authorization form completed and signed.**
- \_\_\_\_\_ 6. **All questions must be answered. Any corrections or scratched out areas must be initialed.**
- \_\_\_\_\_ 7. **If paying by credit card you may fax your application to us at 678-387-1148. If you do not receive a confirmation call or email by the end of the next business day after your fax, please call.**

**Mail all of the above to:**

**Insurance Now  
9 Dunwoody Park  
Suite 136  
Atlanta, GA 30338**

**Please call with any questions you may have.  
(770) 396-9517 or toll-free at (877) 711-8376  
Thank you!**



# INDIVIDUAL PRODUCT ENROLLMENT APPLICATION



APPLICANT SOCIAL SECURITY NO.			

3350 Peachtree Road • Atlanta, GA 30326

Please Print Clearly • Use Black Ink Only

**Type of Contract:**  Individual  Family (Applicant must be oldest adult member)

SEX	LAST NAME	FIRST NAME	M.I.	HEIGHT	WEIGHT
<input type="checkbox"/> M <input type="checkbox"/> F					

AGE	BIRTHDATE	Month/Day/Year	SOCIAL SECURITY NO.	MARITAL STATUS	REQUESTED EFFECTIVE DATE
				<input type="checkbox"/> Married <input type="checkbox"/> Single	

Has anyone listed on this application ever been covered by Blue Cross and Blue Shield of Georgia or Blue Cross Blue Shield Healthcare Plan of Georgia?  YES  NO If yes, under what member ID# \_\_\_\_\_ . Dates From \_\_\_\_\_ to \_\_\_\_\_

### RESIDENCE ADDRESS

STREET ADDRESS					
CITY				STATE	ZIP CODE
HOME PHONE NO. (REQUIRED)			DAYTIME PHONE NO. (REQUIRED)		
E-MAIL ADDRESS					
COUNTY				Is your home inside the city limits? <input type="checkbox"/> YES <input type="checkbox"/> NO	

### BILLING ADDRESS

STREET ADDRESS OR P.O. BOX					
CITY				STATE	ZIP CODE

### PLAN SELECTION

<b>Blue Value Select PPO</b> <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> Consumer Choice Option	<b>Blue Value PPO</b> <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> Consumer Choice Option	<b>Other Medical Plans</b> <input type="checkbox"/> HSA Compatible/HDHP PPO <input type="checkbox"/> Consumer Choice Option <b>Individual HDHP PPO</b> 80% Coinsurance \$ _____ (Deductible) 100% Coinsurance \$ _____ (Deductible)	<b>Additional Coverage</b> <input type="checkbox"/> Mental Health Rider <input type="checkbox"/> Dental <input type="checkbox"/> Blue Vision <input type="checkbox"/> High <input checked="" type="checkbox"/> Mid <input type="checkbox"/> Low <input type="checkbox"/> Term Life
<b>FlexPlus</b> <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	<b>Right Plan PPO</b> <input type="checkbox"/> Right Plan Zero Deductible <input type="checkbox"/> Consumer Choice Option	<b>Family HDHP PPO</b> 80% Coinsurance \$ _____ (Deductible) 100% Coinsurance \$ _____ (Deductible)	

**Billing Type:**  Monthly Bank Draft - First month check, credit or cash required, draft to begin second month.  
 (Note: Complete Bank Draft Authorization on page 5)  
**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BLUE CROSS AND BLUE SHIELD OF GEORGIA**

<b>Credit Card Information First Month Only:</b>	<input type="checkbox"/> MC <input type="checkbox"/> Visa <input type="checkbox"/> Discover Credit Card # _____ Exp. Date _____ month/year Name as it appears on Credit Card _____
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Note: Please make a copy of the signed application for your records prior to submitting to Blue Cross and Blue Shield of Georgia.

FOR INTERNAL USE	DCN	LIST BILL	ACN

SALES AGENT USE ONLY						
REP. NO.	CTY. CODE	AREA	DEDUCTIBLE	MTHLY PREMIUM	AGENT SIGNATURE	E-MAIL ADDRESS:
					<i>Robert W. Ryals</i>	
				AMT RECEIVED	PRINT NAME:	FAX NO.:

APPLICANT SOCIAL SECURITY NO.

Will you or any dependents on this application have any other medical coverage after this policy is effective?  YES  NO

Who is covered?  Self  Spouse  Family Insurance Effective Date: --

Policy Holder Name: \_\_\_\_\_ Birth Date: --

Policy Number: \_\_\_\_\_ Insurance Company Name/Address: \_\_\_\_\_

After coverage begins, will you or any dependents have Medicare/Medicaid? (check one)  YES  NO

Are you eligible for Medicare?  YES  NO Part A Effective Date -- Part B Effective Date --

Is your spouse eligible for Medicare?  YES  NO Part A Effective Date -- Part B Effective Date --

MEDICARE HIC#  Is Medicare coverage related to end stage renal disease?  YES  NO

**If this is an application for a Family Contract, list all eligible dependents. This includes spouse and all unmarried, dependent children, stepchildren, or legally adopted children under age 19 or as otherwise mandated by state law. List dependents in order of age, beginning with the oldest. NOTE: if not a biological parent, complete CERTIFICATE OF DEPENDENCY form.**

RELATION	SEX	LAST NAME	FIRST NAME	M.I.	HEIGHT	WEIGHT	AGE	BIRTHDATE Month/Day/Year	SOCIAL SECURITY NO.	FULL-TIME STUDENT	BIOLOGICAL CHILD?
Spouse	<input type="checkbox"/> M	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>		
	<input type="checkbox"/> F	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>		
Child	<input type="checkbox"/> M	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> F	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	<input type="checkbox"/> M	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> F	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	<input type="checkbox"/> M	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> F	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	<input type="checkbox"/> M	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> F	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	<input type="checkbox"/> M	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> F	<input type="text"/>	<input type="text"/>	<input type="text"/>					<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICANT SOCIAL SECURITY NO.					

### MEDICAL INFORMATION

**HEALTH QUESTIONS:** All of the following questions must be answered with respect to each person for whom you are applying for coverage. Indicate if anyone listed on this application EVER had medical advice, treatment, or if you have reasons to know of health problems in regard to the following, then check YES or NO to each question. Questions answered "yes" must be explained in detail, listing physicians' information in the space provided.

- |   |  |
|---|--|
| <p><b>(A) Yes No</b></p> <ol style="list-style-type: none"> <li>1. <input type="checkbox"/> <input type="checkbox"/> Impairment of Sight, Speech or Hearing</li> <li>2. <input type="checkbox"/> <input type="checkbox"/> Eyes, Ears, Nose, Throat, Head or Brain Disorder</li> <li>3. <input type="checkbox"/> <input type="checkbox"/> Disease of Endocrine System, Thyroid, Goiter or Diabetes</li> <li>4. <input type="checkbox"/> <input type="checkbox"/> Asthma, Sinus, Nasal, Allergies or Lung Disorder</li> <li>5. <input type="checkbox"/> <input type="checkbox"/> High or Low Blood Pressure, Heart Trouble or Vascular Disease</li> <li>6. <input type="checkbox"/> <input type="checkbox"/> Spine Condition or Bodily Deformity</li> <li>7. <input type="checkbox"/> <input type="checkbox"/> Disease of Bones or Joints, Arthritis or Rheumatism</li> <li>8. <input type="checkbox"/> <input type="checkbox"/> Ulcers or Stomach Disorders</li> <li>9. <input type="checkbox"/> <input type="checkbox"/> Kidney, Bladder or Prostate Disorder</li> <li>10. <input type="checkbox"/> <input type="checkbox"/> Gallbladder, Liver Disorder, or Hepatitis</li> <li>11. <input type="checkbox"/> <input type="checkbox"/> Menstrual Disturbances or other Female Disorders</li> <li>12. <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids, Intestinal or Rectal Disorder</li> <li>13. <input type="checkbox"/> <input type="checkbox"/> Hernia</li> <li>14. <input type="checkbox"/> <input type="checkbox"/> Nervous or Mental Disorder</li> <li>15. <input type="checkbox"/> <input type="checkbox"/> Fainting Attacks, Convulsions, or Epilepsy</li> </ol> <p><b>(B) Has any person listed on the application:</b></p> <ol style="list-style-type: none"> <li>1. <input type="checkbox"/> <input type="checkbox"/> Ever been advised to undergo a surgical operation which was not performed?</li> <li>2. <input type="checkbox"/> <input type="checkbox"/> Been advised to undergo surgery within the next six months?</li> </ol> | <p style="text-align: center;"><b>Yes No</b></p> <ol style="list-style-type: none"> <li>16. <input type="checkbox"/> <input type="checkbox"/> Substance Abuse, Drug or Alcohol Abuse</li> <li>17. <input type="checkbox"/> <input type="checkbox"/> Blood Disorder, Anemia, Leukemia, or Hemophilia</li> <li>18. <input type="checkbox"/> <input type="checkbox"/> Tumor, Cyst or Cancer</li> <li>19. <input type="checkbox"/> <input type="checkbox"/> Is anyone listed on this application currently pregnant, in the process of adoption, or becoming a surrogate mother?</li> <li>20. <input type="checkbox"/> <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Kaposi Sarcoma, Pneumocystis Carinii Pneumonia, or Antibodies to Human T-Lymphotropic Virus Type III (HTLV-III)</li> <li>21. <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted diseases such as syphilis, gonorrhea, herpes, or genital warts</li> <li>22. <input type="checkbox"/> <input type="checkbox"/> Any other medical or surgical advice or treatments, hospitalizations, or chronic or recurring minor ailments.</li> <li>23. <input type="checkbox"/> <input type="checkbox"/> Do you now or have you ever, or anyone you are applying for, ever used tobacco products?</li> </ol> <p><b>(B) 3.</b> <input type="checkbox"/> <input type="checkbox"/> Been refused or had health insurance cancelled?</p> <p><b>4.</b> <input type="checkbox"/> <input type="checkbox"/> Ever had medical advice, treatment or any known indications of health problems not mentioned in the questions <i>above</i>?</p> |
|---|--|

NAME AND COMPLETE ADDRESS OF DOCTOR(S) SEEN BY APPLICANT WITHIN LAST 2 YEARS

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NAME AND COMPLETE ADDRESS OF DOCTOR(S) SEEN BY SPOUSE WITHIN LAST 2 YEARS

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NAME AND COMPLETE ADDRESS OF PEDIATRICIAN(S) SEEN BY ANY CHILDREN LISTED ON THIS APPLICATION WITHIN LAST 12 MONTHS

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**List below full details to questions answered "YES" in Sections A and B. If doctor has been seen in the last 2 years, give reason for visit. If additional space is needed, list on a separate sheet of paper and attach to this application.**

Health Question #	Person Treated	Name of Illness or Disorder	Type of Treatment Received	Treatment Dates		Name & Address of Attending Physician or Pediatrician
				From	To	

**Prescription Medications - List all medications taken within the last 12 months by any family member listed on this application. If additional space is needed, list on a separate sheet of paper and attach to this application.**

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name, Phone No. of Prescribing Physician
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____





APPLICANT SOCIAL SECURITY NO.									

**BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS**

I hereby authorize **Blue Cross and Blue Shield of Georgia, Inc.** to draw checks, drafts, orders or electronic funds transfer on the 5th day of each month (EFT) upon my account at the:

_____	_____
NAME OF BANK	CHECKING ACCOUNT NUMBER
_____	_____
STREET ADDRESS OF BANK	CITY, STATE, ZIP CODE OF BANK

for the purpose of paying premiums on insurance issued by Blue Cross and Blue Shield of Georgia, Inc.

I understand if any check, draft, order or EFT transmission is returned due to **payment stopped** or **authorization cancelled**, this will be considered as my request to be billed directly.

_____	_____
CONTRACT HOLDER'S NAME	SOCIAL SECURITY NUMBER
_____	_____
CONTRACT HOLDER'S ADDRESS	CITY, STATE, AND ZIP CODE

_____	<b>X</b>	_____	_____
PRINTED SIGNATURE OF ACCOUNT HOLDER		SIGNATURE OF ACCOUNT HOLDER	DATE

**NOTE: A VOIDED CHECK MUST BE ATTACHED TO THIS APPLICATION.**

First request for bankdraft plan

**Complete entire form and attach a voided check.**

**INSTRUCTIONS FOR COMPLETING THE BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS**

**Automatic Premium Payment Plan**

**What is it** - A special arrangement for payment of premiums automatically each month to relieve you of concern with due dates and the possibilities of having your insurance lapse unintentionally.

**Who can use it** - Bankdraft is an extra convenience for you. It is available if you maintain a regular checking account at your bank and make arrangements with your bank to honor automatic checks and electronic fund transfers.

**How it works** - To initiate the bankdraft, you must complete the authorizations above.

**INSTRUCTIONS**

- 1. Complete as follows:**
  - A. Fill in the name of your bank, branch, branch number (*if any*) and the city or state in which the bank or the branch is located.
  - B. Print the name of your account exactly as it appears on your bank statement or check.
  - C. Include your checking account number. It will usually be found below the signature line of your personal checks.
  - D. Sign your name exactly as you do on your personal checks. If there is more than one depositor, all should sign.
  - E. Include the date you signed the authorizations.
- 2. Attach a VOIDED check and this completed form.** Please be sure the sample check is drawn on the same account as will be used for the automatic premium payment plan.
- 3.** The coverage provided by this policy may be terminated by you upon thirty (30) days **written** notice.
- 4.** Written notice thirty (30) days in advance as stated above in No. 3 is preferred. However, if any check is returned for **payment stopped** or **authorization cancelled**, this will be considered as your request to be billed directly. No further checks will be presented for payment to your bank. If a draft is returned for any other reason, you will be notified by Blue Cross and Blue Shield of Georgia of what is required to pay the premium.

**INTERNAL USE ONLY**

DCN #: _____
BANK #: _____



## Instructions for Completing the BCBSGA Conditioned Authorization to Use or Disclose Protected Health Information for Enrollment in a Health Plan

This instruction sheet has been created to assist you in completing the Blue Cross and Blue Shield of Georgia (BCBSGA) "Conditioned Authorization for Use or Disclosure of Protected Health Information for Enrollment in a Health Plan" form. This form is used to authorize BCBSGA, its agents or subsidiaries, to use or disclose your Protected Health Information (PHI) for the purposes stated on the form. These instructions are designed to complement the information and instructions on the actual authorization form.

- General instructions:
  - Each family member over the age of 18 must individually sign (authorize) Blue Cross and Blue Shield of Georgia (BCBSGA) to obtain medical information that may be necessary to support their enrollment in a BCBSGA health care insurance product. This form and instructions are designed to assist in supporting this effort should it be required.
  - If you are unsure of how to complete any entry, after reading this form, please ask a BCBSGA Customer Care Associate, your Agent / Broker or the BCBSGA Associate that is assisting with the enrollment process for assistance.
- Specific instructions:
  - Please date the form in the space provided. This should be the same date as entered on your application. In the space to the right of the date, please enter the Social Security Number of the applicant or contract holder.
  - For each member over the age of 18, please print the name of the applicant, spouse or dependent on the applicable line on the left-hand side of the form.
  - After printing each individual's name, please have each individual sign in the corresponding space on the right hand side of the form. The signature should be in the same format as that used on your enrollment application.
  - In the event more dependents exist than the space provided, please copy the original enrollment form prior to signature, and repeat the process outlined above. The forms should be labeled, in the upper right hand corner: Page 1 of 2, Page 2, of 2 etc.
  - Date the form (or each form) in the space provided.
- Legal representative: If your legal representative or guardian completes the form on your behalf, they should sign and date the authorization in the block shown and attach documentation supporting their status as your legal representative (e.g., Health Care Power of Attorney, court order, proof of legal custody or guardian status, etc.).
- Please make a copy of this authorization and retain it in your records. Then include the completed authorization form in your enrollment package or provide it to the Broker / Agent or the BCBSGA Associate that is assisting you with the enrollment process.



# Conditioned Authorization to Use or Disclose Protected Health Information for Enrollment in a Health Plan

*Please print clearly and use only black ink.*

By signing below, I authorize Blue Cross and Blue Shield of Georgia (BCBSGA) to obtain any necessary medical records from any physicians, hospitals and/or any other health care providers concerning my care and the care of any family member listed on my Application. I understand this information will be used to determine whether my listed family members and I are eligible for enrollment in the coverage requested.

I understand that BCBSGA will not process my Application for enrollment unless this Authorization is signed and returned with my Application. This Authorization permits BCBSGA to request from health care providers any additional medical information needed to determine my eligibility for coverage and/or the eligibility of any family members listed on my Application. This Authorization will expire within one (1) year from the date indicated below.

I understand that I may revoke this Authorization at any time during the Application process by submitting a completed Authorization Revocation Form to BCBSGA. I may request an Authorization Revocation Form by contacting BCBSGA or the Broker / Agent assisting with my enrollment. If I revoke this Authorization, I understand that I / we will not be considered by BCBSGA for enrollment in a health plan.

Date: \_\_\_\_\_

\_\_\_\_\_  
*Enter Applicant Social Security Number*

\_\_\_\_\_  
*Printed name of Applicant*

\_\_\_\_\_  
*Signature of Applicant or Applicant's Personal Representative*

\_\_\_\_\_  
*Printed name of Spouse or Dependent Child over age 18 listed on Application*

\_\_\_\_\_  
*Signature of Spouse or Dependent Children over age 18 listed on the Application\**

\_\_\_\_\_  
*Printed name of Dependent Child over age 18 listed on Application*

\_\_\_\_\_  
*Signature of Dependent Child\**

\_\_\_\_\_  
*Printed name of Dependent Child over age 18 listed on Application*

\_\_\_\_\_  
*Signature of Dependent Child\**

*\*If listed on your application, your spouse and each dependent child over age 18 must sign above.*

### Designated Legal Representative / Guardian

If this form is signed by a legal representative / guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the ability of the legal representative to act on the individual's behalf, must be attached.

Legal representative (print full name): \_\_\_\_\_

Legal relationship to individual: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please Keep A copy of this Conditioned Authorization Form for your Records*

**CONDITIONAL RECEIPT**

THIS RECEIPT DOES NOT PROVIDE ANY COVERAGE UNTIL ALL THE TERMS AND CONDITIONS LISTED BELOW ARE MET.

Blue Cross and Blue Shield of Georgia (BCBSGA) has received from the named Applicant an advance deposit equal to the first month's dues together with an application for designated health insurance coverage. Such payment is accepted subject to the following conditions:

Subject to the provisions of the contract, the coverage applied for will be effective from, and the contract date as of, the day following acceptance by Medical Underwriting, unless otherwise specifically stated, provided that the payment evidenced by this receipt is the full first month's dues and provided that BCBSGA determines that as of the date of the application all proposed covered persons were acceptable for coverage and for the benefits applied for.

If the application is not approved by BCBSGA said Plan shall incur no liability and the payment evidenced by this receipt will be refunded to the applicant.

No one has the authority to waiver or modify any of the terms or conditions of this receipt.

If you do not receive a contract within 60 days, please contact Blue Cross and Blue Shield of Georgia Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

**ABBREVIATED NOTICE OF INSURANCE  
INFORMATION PRACTICES**

PRIVACY ACT. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. We need your answers to decide if you qualify for coverage. We are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals.

ALL DATA CONFIDENTIAL. Official Code of Georgia, code section 33-39-5, subsection (c) (1 through 4) requires that:

1. Personal information may be collected from persons other than the individual or individuals proposed for coverage;
2. Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization;
3. A right of access and correction exists with respect to all personal information collected;
4. The notice prescribed in subsection (b) of the above referenced Code section will be furnished to the applicant or policyholder upon request.

ACCESS TO YOUR DATA. You have the right to see or obtain a photocopy of your personal information which we have. You also have the right to send us a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of our information practices, please contact Blue Cross and Blue Shield of Georgia Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

**FOR STATISTICAL PURPOSES ONLY**

The following information is requested for statistical purposes including the compilation of data indicating the incidence of specific disease, condition or treatment patterns. It is not required to process your application and you may decline to answer if you prefer.

Please √ the category that best describes your ethnic background.

- American Indian / Alaskan Native     Black / African American Mexican, Mexican American  
 Asian, Asian-American, or Pacific Islander     Puerto Rican     Other Hispanic or Latin     White (non-Hispanic)

Other 

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Primary Language 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Secondary Language 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--