

# *Individual and Family Dental Plan*



BlueCross  
BlueShield  
of Georgia



# **Individual and Family Dental Plan**

***Blue Cross and Blue Shield of Georgia (BCBSGA) offers you and your family a dental plan to help keep your teeth healthy and your smile bright. Our plan gives you the option of going to any dentist you choose. However, you may pay more out-of-pocket when you visit a dentist who is not a BCBSGA contracted dentist.***

Hundreds of dedicated professionals have contracted with BCBSGA to provide a wide range of dental services such as routine check-ups, cleanings, fillings, crowns, and dental surgery.

When you receive services from a BCBSGA contracted provider, you'll almost never file a claim. That means there's virtually NO paperwork. And that takes the hassle out of going to the dentist.

The Plan was designed with two goals in mind:

1. First and foremost, to promote good dental hygiene and preventive care, important elements in a total health care package.
2. To provide you with the dental care you need in a convenient, cost-conscious manner, therefore providing many dental services at reduced costs.

The Plan features low-cost preventive and diagnostic care, basic dental care, and a benefit schedule that can help you offset the high cost of major dental care. Please read the following information for details about how the Plan works, specific benefit information and certain exclusions and limitations that apply.

## **Contracted Dentists**

A large number of dentists in Georgia have agreed to provide services at contracted rates to BCBSGA members and are known as contracted dentists.

When you choose a contracted dentist, you will receive dental care at negotiated discounted rates. Should you choose to visit a non-contracted dentist, the Plan still provides benefits but your out-of-pocket costs may be greater as the negotiated fees do not apply to non-contracted dentists. You will be responsible for any charges in excess of the stated benefit for both contracted and non-contracted dentists.

The Plan lets you know before your dentist visit how much BCBSGA pays for covered services. This means that you are able to easily calculate how much you will have to pay once you have determined your dentist's fee for your specific procedures.

**The following is an EXAMPLE of BCBSGA's Scheduled Benefit Plan and how negotiated fees may save you out-of-pocket costs. Negotiated fees may vary among contracted dentists.**

## **Contracted Dentist**

|   |              |
|---|--------------|
| If the billed charges are   | <b>\$735</b> |
| And BCBSGA's negotiated rate is   | \$575        |
| BCBSGA will pay the amount specified in the benefit schedule                              | \$250*       |
| Therefore, you pay the difference between the negotiated amount and the scheduled benefit | <b>\$325</b> |

*\*Assuming that your deductible has been met and your annual benefit maximum has not been exceeded, BCBSGA will pay this amount.*

## **Noncontracted Dentist**

|   |              |
|---|--------------|
| If the billed charges are   | <b>\$735</b> |
| BCBSGA will pay the amount specified in the benefit schedule                          | \$250*       |
| Therefore, you pay the difference between the billed amount and the scheduled benefit | <b>\$485</b> |

*\*This assumes any deductible has been met and you have not reached your annual maximum.*

# Helpful Questions and Answers

**How do I know if my dentist is a BCBSGA contracted dentist?** Simple. Visit [www.bcbsga.com](http://www.bcbsga.com) and select “Provider Directory.” You can search for either nearby dentists or a specific dentist. You can also print out step-by-step driving directions from your home/office to the dentist’s office. You can also call customer service at 1-888-209-7852 Monday - Thursday from 8 am to 10 pm and on Fridays from 8 am to 8 pm.

**Do I have a deductible, and if I do, what is the amount?** Yes. You are responsible for a yearly \$50 per person deductible, with a maximum of three deductibles (\$150) per family, before your benefits for covered services are available.

**Is there a maximum of how much BCBSGA will pay each year toward my dental care?** Yes. All dental benefits are limited to a maximum of \$1,000 for expenses incurred by each enrolled member during a calendar year.

**Who do I call if I have questions about my dental coverage?** BCBSGA’s dedicated customer service associates are available to assist you with questions about your plan. The toll-free number is 1-888-209-7852.

## Monthly Premium Rates

To determine your premium, see the enclosed Dental Rate Card. If you have any questions, please consult your agent or call the dental customer service department at 1-888-209-7852.

## Preventive and Diagnostic Care

- Coverage begins on your effective date.
- The benefit schedule is the same for both contracted and noncontracted dentists, but you may pay more if you choose a noncontracted dentist.
- Two oral examinations and two dental cleanings per member, per year.
- Total benefit for single and bitewing X-rays not to exceed benefit for full mouth - \$47.

| Procedure  | BCBSGA Pays |
|--|-------------|
| <b>Initial Oral Exam</b>   | <b>\$16</b> |
| <b>Periodic Oral Exam -</b><br><i>limited to 2 exams per member per year</i> | <b>\$16</b> |
| <b>Bitewing X-rays - single film</b>   | <b>\$9</b>  |
| <b>Bitewing X-rays - two films</b>   | <b>\$16</b> |
| <b>Single (periapical) X-rays - first film</b>                               | <b>\$9</b>  |
| <b>Single X-rays - additional films</b>                                      | <b>\$9</b>  |
| <b>Bitewing X-rays - four films</b>  | <b>\$23</b> |
| <b>Full mouth X-rays -</b><br><i>limited to one set every 3 years</i>        | <b>\$47</b> |
| <b>Routine Cleaning -</b><br><i>limited to 2 per adult per year</i>          | <b>\$37</b> |
| <b>Routine Cleaning -</b><br><i>limited to 2 per child per year</i>          | <b>\$26</b> |
| <b>Cleaning with Fluoride -</b><br><i>limited to 2 per child per year</i>    | <b>\$37</b> |
| <b>Topical Fluoride Only -</b><br><i>limited to 2 per child per year</i>     | <b>\$14</b> |

*Adult – Any person or dependent 19 years or older covered by this plan.*

*Child – Any person or dependent 18 years or younger covered by this plan.*

# Basic Dental Care

- Coverage begins after the Plan has been in effect for six continuous months.
- The benefit schedule is the same for both contracted and noncontracted dentists, but you may pay more if you choose a noncontracted dentist.

| Procedure  | BCBSGA Pays |
|--|-------------|
| <b>Filling</b> - one surface, primary              | \$35        |
| <b>Filling</b> - one surface, permanent            | \$42        |
| <b>Filling</b> - two surfaces, primary             | \$47        |
| <b>Filling</b> - two surfaces, permanent           | \$52        |
| <b>Filling</b> - three surfaces, primary           | \$55        |
| <b>Filling</b> - three surfaces, permanent         | \$62        |
| <b>Filling</b> - four or more surfaces, primary    | \$68        |
| <b>Filling</b> - four or more surfaces, permanent  | \$76        |
| <b>Extraction</b> - single tooth (simple)          | \$43        |
| <b>Extraction</b> - each additional tooth (simple) | \$43        |
| <b>Surgical Extraction</b>                         | \$72        |
| <b>Removal of Impacted Tooth</b> - soft tissue     | \$100       |
| <b>Removal of Impacted Tooth</b> - partial bony    | \$126       |
| <b>Removal of Impacted Tooth</b> - complete bony   | \$150       |

## Major Dental Care

- Coverage begins after the Plan has been in effect for twelve continuous months.
- The benefit schedule is the same for both contracted and noncontracted dentists, but you may pay more if you choose a noncontracted dentist.

| Procedure                                | BCBSGA Pays  |
|--|--------------|
| <b>Scaling/Root Planing per Quadrant</b> | <b>\$48</b>  |
| <b>Gingivectomy - per tooth</b>          | <b>\$30</b>  |
| <b>Gingivectomy - per quadrant</b>       | <b>\$140</b> |
| <b>Root Canal - 1 canal</b>              | <b>\$150</b> |
| <b>Root Canal - 2 canals</b>             | <b>\$180</b> |
| <b>Root Canal - 3 canals</b>             | <b>\$230</b> |
| <b>Crown (except stainless steel)</b>    | <b>\$250</b> |
| <b>Stainless Steel Crown</b>             | <b>\$60</b>  |
| <b>Pontic</b>                            | <b>\$250</b> |
| <b>Complete Denture (upper or lower)</b> | <b>\$300</b> |
| <b>Partial Denture (upper or lower)</b>  | <b>\$275</b> |
| <b>Denture Reline (chair-side)</b>       | <b>\$65</b>  |
| <b>Denture Reline (lab)</b>              | <b>\$85</b>  |

## Date Coverage Begins

The effective date of your coverage is printed on your member ID card. Your coverage will stay in effect with our consent, on a monthly basis.

## Terms of Coverage

Coverage under this Plan remains in force as long as the required premiums are paid on time and as long as the insured remains eligible for coverage. If your spouse becomes ineligible for coverage under this Plan because of death of the policyholder or divorce, he or she may obtain a similar Plan through BCBSGA. The new Plan will have the same benefits as this Plan. Other insured family members who are no longer eligible due to age or who no longer qualify as depend-

ents for coverage under this Plan may also obtain a similar plan through BCBSGA. To be eligible for this conversion privilege, you must contact BCBSGA within 31 days after the loss of eligibility to request coverage. Any and all probationary and/or waiting periods in the new Plan will be considered as being met to the extent coverage was in force under this plan. BCBSGA may refuse to renew or may change the premiums of this Plan after 60 days written notice to the policyholder. However, BCBSGA will not refuse to renew or change the premium schedule for this Plan on an individual basis, but only for all policyholders in the same class and covered under the same Plan as you.

## ***Other Insurance with This Insurer***

Insurance effective at any one time on the insured under a like Plan or Plans with this insurer is limited to the one such Plan elected by the insured, the insured's beneficiary or estate, as the case may be, and the insurer will return all premiums paid for all Plans.

## ***Eligibility and Enrollment***

To be eligible for enrollment, you must be:

- A resident of the State of Georgia who applies for coverage and is accepted by BCBSGA
- A resident of the United States for at least six months, age younger than 65
- The applicant's lawful spouse of the opposite sex, age younger than 65
- The applicant's unmarried child up to age 19
- The applicant's unmarried child who is a full-time student up to age 26
- Not enrolled under any other individual or group dental policy
- Unmarried stepchildren who reside with the applicant up to age 19 or if a full-time student (12 credit hours), age 19 through 26

## **How to Enroll**

### **If you are a new member and want dental coverage ONLY:**

- Complete and sign the attached application and Bank Draft Authorization form.
- Determine your premium from the enclosed Individual/Family Dental Rate Card.
- Send the application and completed Bank Draft Authorization form to your agent or the BCBSGA address below.

### **For those applying for BCBSGA medical coverage and dental coverage:**

- Contact your agent or BCBSGA.

### **For BCBSGA members who want to ADD dental:**

- Complete the attached application.
- Determine your premium from the enclosed Individual/Family Dental Rate Card.
- You must send the first month's premium with the application.
- Write a check payable to BCBSGA.
- Send the application and and completed Bank Draft Authorization form to your agent or the BCBSGA address below.

### **Send your application and payment to:**

**Blue Cross and Blue Shield of Georgia**  
**3350 Peachtree Road**  
**MSC GOO302**  
**Atlanta, GA 30326**

Applicants who are approved for enrollment will receive a BCBSGA Individual Dental Plan Contract. Please review it carefully as it contains specific details about your benefits, coverage, exclusions and limitations. This brochure only provides highlights of the BCBSGA Individual Dental Plan. This is not the contract and only the actual Plan provisions will apply.

## Exclusions and Limitations

The BCBSGA Individual and Family Dental Plan does not provide benefits for:

- **Unlisted services:** Services not specifically listed in the benefit schedule of this policy.
- **Excess amounts:** Any amounts in excess of the maximum amount stated in the “calendar year maximum benefit” section or listed in the benefit schedule.
- **Experimental or investigative procedures:** Services or supplies that we consider being experimental or investigative.
- **Expenses before coverage begins:** Services received before your effective date.
- **End of coverage:** Services received after your coverage ends.
- **Services for which you are not legally obligated to pay:** Services for which no charge would be made to you in the absence of insurance coverage.
- **Workers’ compensation:** Any condition for which benefits could be recovered, either by adjudication, settlement or otherwise, under any workers’ compensation, employer’s liability law or occupational disease law, even if you do not claim those benefits.
- **War:** Disease contracted or injuries sustained as a result of war declared or undeclared, conditions caused by the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- **Government services:** Any services provided by a local, state, county or federal government agency including any foreign government.
- **Services from relatives:** Professional services received from a person who lives in the insured person’s home or who is related to the insured person by blood, marriage or adoption.
- **Cosmetic dentistry:** Any services performed for cosmetic purposes are not covered under this plan, unless they are for the correction of functional disorders or as a result of an accidental injury occurring while you were covered under this policy.

- **Charges for treatment by other than a licensed dentist or physician**, except charges for dental prophylaxis performed by a licensed dental hygienist, under the supervision and direction of a dentist.
- **Replacement of an existing prosthesis**, which has been lost or stolen, or which in the opinion of the dentist is or can be made satisfactory.
- **Replacement of a fixed or removable prosthesis** if such replacement occurs within five years of the original placement, unless the denture is a stayplate used during the healing period for recently extracted anterior teeth.
- **Orthodontic services**, braces, appliances and all related services.
- **Diagnosis or treatment of the joint of the jaw and/or occlusion** (the way upper and lower teeth meet) services, supplies or appliances provided in connection with: (a) any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint) or associated musculature, nerves and other tissues for any reason or by any means; or (b) any treatment, including crowns, caps and/or bridges to change the way the upper and lower teeth meet (occlusion); or (c) treatment to change vertical dimension (the space between the upper and lower jaw) for any reason or by any means including the restoration of vertical dimension because teeth have worn down.
- **Procedures requiring appliances or restorations** (other than those for replacement of structure lost from cavities) that are necessary to alter, restore or maintain occlusions. These include but are not limited to: (a) changing the vertical dimension; (b) replacing or stabilizing lost tooth structure by attrition, abrasion, or erosion; (c) realignment of teeth; (d) gnathological recording; (e) occlusal equilibration; (f) periodontal splinting.
- **Oral examinations exceeding two visits per insured per year.**
- **Prophylaxis treatments**, exceeding two treatments per insured per year.
- **Fluoride applications for patients over eighteen (18) years of age.** Fluoride applications exceeding two visits per year.

- **More than one set of full-mouth** x-rays or its equivalent per insured in a three-year period.
- **Correction of congenital or development malformation** for an insured person including but not limited to cleft palate, maxillary or mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- **Adjustment, repairs or relines to prosthesis** except following 6 months from initial placement and if the prosthesis was paid for under this plan.
- **Fixed bridges, removable cast partials** and/or cast crown with or without veneers for patients under sixteen years of age.
- **Replacement of crowns and cast restorations** including porcelain crowns, if such replacement occurs within five years of the original placement.
- **Transfer of care:** If a policyholder transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BCBSGA shall be liable only for the amount it would have been liable for had one dentist rendered the services.
- **Prescribed drugs**, pre-medication or analgesia.
- **Oral hygiene instruction.**
- **Malignancies and neoplasms:** Services for treatment of malignancies and neoplasms are not covered services.
- **All hospital costs and any additional** fees charged by the dentist for hospital treatment.
- **Implants** (materials implanted into or on bone or soft tissue), or the removal of implants are not benefits under the policy. However, if implants are provided in association with a covered prosthetic appliance, BCBSGA will allow the benefit for a standard complete or partial denture or a bridge toward the cost of implants and the prosthetic appliances.
- **Services or supplies** that are not medically necessary.
- **Replacement of teeth missing prior** to the effective date of coverage.
- **Services for periodontics**, fixed or removable prosthodontics within the first 12 months of the insured person's effective date.

# Conditional Receipt

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

**DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE BLANK.**

Blue Cross and Blue Shield of Georgia 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:

1. 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 BCBSGA, 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.
2. 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.
3. No one has the authority to waiver or modify any of the terms and 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, PO Box 7368, Columbus, GA 31908-7368.

All premium checks must be made payable to Blue Cross and Blue Shield of Georgia.

## **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 investigated consumer report may be made to help us obtain additional medical data from physicians or hospitals.

### **ALL DATA CONFIDENTIAL.**

We are required by law to keep such data confidential. It will be seen only by employees and authorized agents. This data may in certain circumstances be disclosed without your authorization. We may furnish such data to authorized federal or state agencies, consumer investigative service bureaus or others if part of our standard business practice or required by law.

### **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, PO Box 7368, Columbus, GA 31908-7368.



# ***Individual and Family Dental Plan Rate Card***

| <b>Monthly Dental Rates*</b> |             |
|------------------------------|-------------|
| <b>Subscriber, adult</b>     | <b>\$27</b> |
| <b>Subscriber, child</b>     | <b>\$27</b> |
| <b>Family</b>                | <b>\$76</b> |

\*Rates subject to change.



# Individual/Family Dental Plan Enrollment Application

If you are a BCBSGA subscriber, please enter your current BCBSGA group number and/or member ID number.

MEMBER ID NO.

FOR BCBSGA USE ONLY:

DCN#

### Billing Type

Monthly (*By checking account deduction only. Please complete the enclosed Bank Draft Authorization form.*)

### Applicant Information - Applicant must complete this section.

|   |  |                                    |   |   |                                       |
|---|--|------------------------------------|---|---|---------------------------------------|
| Last Name<br><input type="text"/>   |  | First Name<br><input type="text"/> | MI<br><input type="text"/>  | Social Security No.<br><input type="text"/>                                     |                                       |
| Home Phone No.<br><input type="text"/>  | Business Phone No.<br><input type="text"/> | Age<br><input type="text"/>        | Sex<br><input type="radio"/> M<br><input type="radio"/> F                   | Marital Status<br><input type="radio"/> Single<br><input type="radio"/> Married | Date of Birth<br><input type="text"/> |
| Home Address ( <i>Must be complete. P.O. Box not acceptable</i> )<br><input type="text"/> |  |                                    | Billing Address ( <i>If different or P.O. Box</i> )<br><input type="text"/> |   |                                       |
| City<br><input type="text"/>  | State<br><input type="text"/>              | Zip Code<br><input type="text"/>   | City<br><input type="text"/>  | State<br><input type="text"/>   | Zip Code<br><input type="text"/>      |

### Spouse to Be Insured - Signature required below.

|   |                                    |   |                                       |   |
|---|------------------------------------|---|---------------------------------------|---|
| Last Name of Spouse<br><input type="text"/> | First Name<br><input type="text"/> | Sex<br><input type="radio"/> M<br><input type="radio"/> F | Date of Birth<br><input type="text"/> | Social Security No.<br><input type="text"/> |
|---|------------------------------------|---|---------------------------------------|---|

### Children to Be Insured - Signature required below.

|   |                                    |   |                                       |   |
|---|------------------------------------|---|---------------------------------------|---|
| 1. Last Name of Child<br><input type="text"/> | First Name<br><input type="text"/> | Sex<br><input type="radio"/> M<br><input type="radio"/> F | Date of Birth<br><input type="text"/> | Social Security No.<br><input type="text"/> |
| 2. Last Name of Child<br><input type="text"/> | First Name<br><input type="text"/> | Sex<br><input type="radio"/> M<br><input type="radio"/> F | Date of Birth<br><input type="text"/> | Social Security No.<br><input type="text"/> |
| 3. Last Name of Child<br><input type="text"/> | First Name<br><input type="text"/> | Sex<br><input type="radio"/> M<br><input type="radio"/> F | Date of Birth<br><input type="text"/> | Social Security No.<br><input type="text"/> |
| 4. Last Name of Child<br><input type="text"/> | First Name<br><input type="text"/> | Sex<br><input type="radio"/> M<br><input type="radio"/> F | Date of Birth<br><input type="text"/> | Social Security No.<br><input type="text"/> |

### Signatures (Required)

If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. If the responsible adult is not the natural parent, please submit court papers authorizing guardianship. I understand that coverage is subject to all conditions and provisions specified in the Policy. By submitting an application for coverage, I have authorized every provider furnishing care to disclose all facts pertaining to our care, treatment, and physical conditions, upon your request. I agree to assist in obtaining this information if needed. I understand that receipt of money with this application does not create BCBSGA coverage. Coverage will come into effect only on approval by BCBSGA.

|  |              |   |              |
|--|--------------|---|--------------|
| Signature of Applicant /Parent or Legal Guardian<br><b>X</b> | Today's Date | Signature of Applicant's Spouse<br><b>X</b> | Today's Date |
|--|--------------|---|--------------|

### Agent Information

|                       |              |                                |              |
|-----------------------|--------------|--------------------------------|--------------|
| Name of Agent (Print) | Agent Number | Signature of Agent<br><b>X</b> | Today's Date |
|-----------------------|--------------|--------------------------------|--------------|

Rep No #11473

### FOR BCBSGA USE ONLY

|                                   |                                       |  |  |
|-----------------------------------|---------------------------------------|--|--|
| Group No.<br><input type="text"/> | Member ID No.<br><input type="text"/> | Agent Tax I.D. No.<br><input type="text"/> | Effective Date<br><input type="text"/> |
| Area<br><input type="text"/>      | By<br><input type="text"/>            | Date<br><input type="text"/>               |  |



|                     |  |  |  |  |  |  |  |  |  |
|---------------------|--|--|--|--|--|--|--|--|--|
| 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 (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 check 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 #: _____ |