



Protect your family from the unexpected. Introducing Term Life Insurance from Greater Georgia Life Insurance Company.

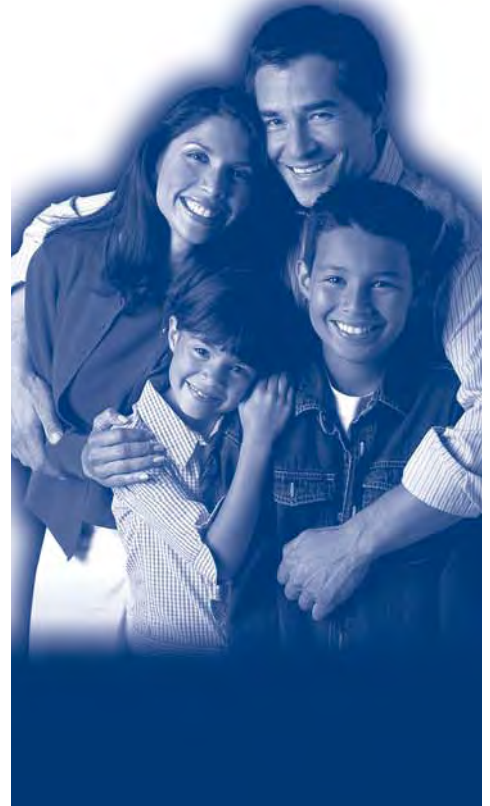
Preparing for the Unexpected

For only a few cents a day, you can provide your family with peace of mind and a little extra support at a time of great loss. This coverage is offered by Greater Georgia Life (GGL), a sister company of Blue Cross and Blue Shield of Georgia (BCBSGA).

Applying for this new Term Life Insurance program is easy. Simply complete the enclosed Individual Term Life Application. If you are accepted for coverage, your life premium will be automatically added to your BCBSGA monthly billing statement.

Apply today and discover the advantages of adding Term Life Insurance to your medical coverage:

- One-stop shopping with Georgia's largest health insurance provider and its sister company, GGL
- Additional peace of mind for you and your family
- One bill for all of your health and life insurance needs
- No additional forms to fill out
- No medical exams
- Coverage for children for as little as \$1.50 per month
- Coverage for adults for as little as \$2.80 per month



Term Life Insurance Monthly Rates

AGE	\$15,000	\$25,000	\$50,000
Under 1	Not available	Not available	Not available
1-19	\$1.50	\$2.50	Not available
20-29	\$2.80	\$4.65	\$9.30
30-39	\$3.25	\$5.40	\$10.80
40-49	\$7.50	\$12.50	\$25.00
50-59	\$20.90	\$34.80	\$69.60
60-64	\$29.40	\$49.00	\$98.00
65+	Not available	Not available	Not available

Get the Power of BlueSM working for you!

Medical plans offered by Blue Cross and Blue Shield of Georgia (BCBSGA). Term life insurance plan offered by Greater Georgia Life Insurance Company (GGL). BCBSGA and GGL are independent licensees of the Blue Cross Blue Shield Association.
SSGGL-0400-00 11/04

*Use this checklist to make sure you
have included all that is required
for Blue Cross term life application*

- _____ 1. *One completed application for all family members who desire coverage (applicant, spouse and/or any full time student under the age of 25). Coverage is not available for children under age 1 or adults over age 65.*
- _____ 2. *IMPORTANT: The oldest person listed on the application must be listed as the primary applicant.*
- _____ 3. *First month's premium for each application. Add the premium for each person desiring coverage in order to get the correct monthly premium amount (check made payable to Blue Cross).*
- _____ 4. *Completed bank draft agreement and voided check (only if paying by automatic bank withdrawal).*
- _____ 5. *All adult applicants must sign and date the application.*
- _____ 6. *All questions must be answered. Any corrections or scratched out areas must be initialed.*

Mail all of the above to:

*Insurance Now
5 Dunwoody Park South
Suite 110
Atlanta, GA 30338*

(Remember to make your check payable to Blue Cross)

*Please call with any questions you may have.
(770) 396-9517*

Thank you!!



Individual Term Life Insurance Application

If you are a BCBSGA member, please enter your current BCBSGA member ID #

FOR HOME OFFICE USE ONLY:

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1. APPLICANT INFORMATION--(Please Print)

APPLICANT'S NAME (LAST, FIRST, MIDDLE)										SEX	BIRTHDATE MM/DD/YY				APPLICANT SOCIAL SECURITY NUMBER					
RESIDENTIAL ADDRESS										CITY				STATE	ZIP CODE					
COUNTY					HOME PHONE NO.					DAYTIME PHONE NO.										
FAX NO.										E-MAIL ADDRESS										

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: (Questions answered "Yes" must be explained in detail in the space provided. If additional space is needed, list on a separate sheet of paper and attach to this application.)

1. Cardiovascular disease or heart attack; stroke; high blood pressure Yes No
2. Disorder of the kidneys, bladder, stomach, intestines or liver Yes No
3. Musculoskeletal, mental or nervous conditions, central nervous system disorders Yes No
4. Diabetes, Emphysema, bronchitis or any chest, lung or respiratory problem or disorder Yes No
5. Cancer or acquired immune deficiency disorder (AIDS), or AIDS-related complex, not including the results of HIV testing Yes No
6. Are you pregnant? Yes No
7. What is your height? Applicant ___ Feet ___ Inches Spouse ___ Feet ___ Inches
8. What is your weight? Applicant _____ Pounds Spouse _____ Pounds

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

2. TERM LIFE INSURANCE COVERAGE SELECTION AND BENEFICIARY

Family Member	Birthday mm/dd/yyyy	Amount of Benefit	Beneficiary Name	Beneficiary Social Security Number	Relationship	Allocation	% allocation
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000		- -		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	_____% _____%
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000		- -		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	_____% _____%
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000		- -		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	_____% _____%
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000		- -		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	_____% _____%

Note: The \$50,000 amount is not available to applicants under the age of 20. If selected by an approved applicant under the age of 20, the selection will default to \$25,000. If a beneficiary is not listed and the Policy is issued, death benefits will be paid according to the Beneficiary Provision in the Policy.

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive an insurer, makes a claim containing any false, incomplete or misleading information to obtain the proceeds of an insurance policy is guilty of a felony.

I apply for the benefits provided by the policy indicated above. I understand that receipt of money with this application does not create coverage. Coverage will come into effect only on approval by Greater Georgia Life Insurance Company.

Date signed / /	Signature of applicant	State of residence
Date signed / /	Signature of spouse	State of residence

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
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FOR SALES AGENT USE ONLY

Rep. No.	County Code	Area	Deductible	Mthly Premium	Agent Signature <i>Robert W. Ryals</i>	E-Mail Address
				Amt. Received	Agent Name:	Fax #: