2017 Open Enrollment Form

Endorsed by Georgia Dental Association

For individual coverage effective January 1, 2017

Please **FAX** completed form to: **(404) 634-6099** or mail to: GDIS, 7000 Peachtree Dunwoody Rd NE, Suite 200, Building 17, Atlanta GA 30328-1655.

All Employees MUST complete an enrollment form or coverage is subject to termination.

Part I: General Information - Please Print Legibly

Name of Dentist/Employer		GDIS Group ID #	
(Applicant) Last Name	First Name	Middle Initial	
(Applicant) Mailing address			
City	State	Zip Code	Hire Date
Home phone no. ( )	Business phone no. ( )	Email	

Part 2: Medical Coverage - Please select your choice:

☐ **ENROLL** (Complete parts 2, 3 & 4) ☐ **CANCEL** - **Effective Date:** _____ (Sign & date below)
(Date must be last day of month)

☐ **WAIVE** coverage (Must state reason for waiver. Sign & date below)

Reason for Waiver: _____

Part 2a: Medical Coverage - Please select your plan: Effective Date: _____

Select ONE of the following plans below:

☐ POS 500 Plan ☐ POS 2500 Plan ☐ POS HDHP

Part 2b: Vision Coverage - Blue View Vision (Optional Coverage)

☐ Blue View Vision Plan

Part 3: Applicant and Covered Dependent Information

	Add	Drop	Name (Last, First MI)	Social Security Number	Date of Birth mm/dd/yyyy	Male	Female
Applicant							
Spouse							
Child							
Child							
Child							

Part 4: Authorization (It is a Federal crime to knowingly provide false information on a medical coverage application)

I REQUEST COVERAGE UNDER THIS GROUP PLAN. I have completed the information on this form. I understand that enrollment in this plan is subject to all the terms of the group plan, and that to be eligible, I must (a) be employed by the named employer in a class eligible for the coverage and (b) engaged in and perform the normal duties of such employment on a regular basis for at least the minimum number of hours per week (excluding duties performed at my residence or while confined in a hospital). I also understand that coverage will not become effective for me or any eligible dependent until all the applicable eligibility requirements of the group plan are met.

- **I understand that coverage will not be effective unless I satisfy the conditions on this form.**
- **I understand that inaccurate answers to the questions on this enrollment form may void my coverage under this plan.**

I hereby acknowledge that Blue Cross and Blue Shield of Georgia/Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSGA/BCBSHP) has informed me of the following prior to my enrollment in their health care coverage plan:
a. number, mix and location of participating/network health care providers;
b. limitations on choices of participating/network health care providers;
c. disclosure of contractual relationship between participating/network provider and BCBSGA/BCBSHP.

Applicant's Signature _____ **Date Signed** _____