



HEALTHCARE ENROLLMENT

Human Resources – Benefits
 One Park Place South, 3rd Floor
 Mailing Address:
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 Office (404) 413-3330
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LAST NAME, First, Middle				Panther #:		HR Empl ID:
Home Address			Marital Status	Campus Phone	Home Phone	Date of Hire:
City	County	State	ZIP	Email Address		Effective Date:

Plan	Group #	Employee Only	Employee + Spouse	Employee + 1 Child	Family
BOR INDEMNITY	USG0090001	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BOR PPO	BOR0090001	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KAISER HMO	0852-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Deductible	BHD0090001	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blue Choice HMO	1000012-090	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Consumer Choice Option (CCO): At an additional premium charge to you of 40% (for the PPO) or 70% (for the HMOs), you can nominate an out-of-network provider for you, subject to plan and provider approval. This election is irrevocable during the plan year. Do you wish to elect the CCO?

No (Default)
 Yes

Last Name, First, MI		(Kaiser & BlueChoice only) Physician Name & ID Number	Date of Birth (MM/DD/YY)	SEX	Dependent Age 19-26 Full Time Student or Disabled?
Self	Name:			M F	
	Physician ID:				
Spouse	Name:			M F	N/A
	Physician ID:				
Child	Name:			M F	Y N
	Physician ID:				
Child	Name:			M F	Y N
	Physician ID:				
Child	Name:			M F	Y N
	Physician ID:				

Eligible dependents for healthcare coverage are defined as: Spouse through legal marriage (unless legally separated); unmarried child through age 18; unmarried child ages 19-26 if enrolled as a full time student in an accredited school (documentation required); stepchild or other child for whom you have assumed a legal obligation (documentation required). A marriage license, birth certificate, or other document establishing a dependent relationship is required for any dependent whose last name differs from yours. Appropriate documents must be submitted for coverage to be activated. Please attach the required documentation to add your spouse and/or dependents, i.e. marriage license, full-time student certification, birth certificates.

I have read and understand the summary of provisions under IRC Sec. 125 (SEE THE BACK OF THIS FORM) and realize that if I make application for health benefits, my premiums for such coverage will be deducted from my salary on a pre-tax basis. The information I have provided is true and complete to the best of my knowledge. I understand that my coverage and benefits may be affected by failure to provide complete and accurate information. I also authorize my healthcare providers to exchange information regarding any person included under my coverage and to provide such information to other healthcare providers and to insurers as necessary for the provision of care, the administration of the service agreement and the settlement of claims. I also consent to the assignment of benefits to the Health Plan which I may have in circumstances where a party other than my Health Plan may be responsible for all or a portion of, the cost of services provided to me. I agree to pay the premium amounts applicable for the contract under which I am covered. I authorize my employer to deduct from payroll such applicable premium amounts and to remit them to the insurance company I have chosen.

SIGNED: _____

DATE: _____

RETURN TO HR (make a photocopy for your records if you wish)
 09/07

For reimbursement, your healthcare plan may restrict your choice of who may treat you or your family, and where you or your family may be treated. (This applies only to the PPO and the HMO health plans.)
www.usg.edu/admin/humres/benefits/health