



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	E-Mail Address
				Amt. Received	Agent Name:	Fax #: