Enclose complete application in self-addressed envelope or return to:
Office of Commissioner of Insurance
Room 716 West Tower
2 Martin Luther King, Jr. Drive
Atlanta, GA 30334
Attn: J.Robinson / S.Neal

Georgia Department of Insurance
FORM APP-ASSIGN
Revised 02/11

404-657-6041
fax# 404-657-8542

Individual Eligibility Application for the State of Georgia Assignment System

This application must be completed for individuals who are applying for coverage under the State of Georgia individual assignment system. In order to be eligible for coverage under this program, the Administrator must receive this application no later than 63 days following your termination of coverage under your group plan's continuation of benefits. You may use the enclosed self-addressed envelope or send the application to the address above. Submission of this application does not guarantee coverage. The Administrator and/or insurance company reserves the right to review your responses to determine eligibility for coverage under this plan for you and your dependents.

Upon your assignment to an insurer by the Administrator, the insurer will have 10 business days in which to verify your eligibility. You will be notified of your eligibility status following the insurer's review. The insurer reserves the right to request additional eligibility documentation if your application is incomplete or if the information provided is insufficient to make a determination of eligibility. Based on the final review, coverage may be denied if it is determined that you do not satisfy the eligibility criteria. If it is determined that you are eligible for coverage, the insurer will send you information on benefit options and premium rates. Premiums will be due retroactive to the date that your group coverage or continuation terminated. Your coverage will be effective on the date your group coverage or continuation terminated.

This form must be completed for **all** individuals for whom coverage is being applied. Failure to include an individual may result in the denial of coverage for that individual. **In order to facilitate the review of eligibility, you must submit any certifications of credible coverage for the last 18 months of health coverage for yourself, your spouse, and dependents if applicable.** If you do not have certifications of credible coverage available, contact your previous employer, claims administrator, or insurer. If you do not submit all or any applicable certifications of credible coverage, the insurer to which you are assigned may request evidence of previous coverage in order to determine eligibility. Failure to comply with requests may result in refusal to offer coverage.

Please specify **date of termination** of coverage under most recent group health plan (including any COBRA or continuation of benefits):
___________/____________/___________(month/date/year) Explain any differences in termination dates for any dependents and additional certifications of creditable coverage (as necessary) for such dependents:

____

(First) (Middle) (Last) (Social Security No.) (Sex) (Birth date)

		M/F	M	D	Y
	_ _				
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Address:		County:	
City:	State: Zip:	Phone(Home):	Phone(Business):
Current Employer:	Employer Phone:	Spouse's Employer:	Employer Phone:

Eligibility Questions: Please answer the following questions for you and for any dependents that would be applying for coverage under this plan: *(words in bold print are defined in the attached glossary)*

	Yes	No
1. Do all proposed insureds reside in the state of Georgia?	( )	( )
2. Was the most recent medical coverage under a group health plan for all proposed insureds?	( )	( )
3. Was the most recent group health plan a **self insured plan**?	( )	( )
4. Have all the proposed insureds completely exhausted any COBRA or continuation coverage available?	( )	( )
5. Do all the proposed insureds have at least 18 months of **credible coverage,** the most recent being under a group health plan, without a break in coverage of more than 63 days?	( )	( )
6. Have you included a certification of credible coverage for each individual for whom you are applying coverage?	( )	( )
7. Are any of the proposed insureds eligible for medical coverage through an employer or spouse's employer ?	( )	( )
8. Are any of the proposed insureds currently covered under any type of health plan or health insurance policy?	( )	( )
9. Are any of the proposed insureds eligible for Medicare or Medicaid?	( )	( )
10. Did your previous employer/administrator/group health insurer offer coverage to you or any of the proposed insureds through an **enhanced conversion option or policy**?	( )	( )

11. Indicate the employer who offered you your most recent group health plan, and the claim administrator for that plan, or the insurer if applicable.

Employer:___________________________________ Phone# (Benefits contact if available)________________________

Claim Administrator:____ Phone#___________________________

Insurer:____ Phone#___________________________

12. Under what type of group health plan did you most recently have coverage? **HMO/EPO______ Traditional indemnity or PPO______ Other(Please explain)**____

If you answered "No" to any question, 1-6, "Yes" to any question 7-10, or need to further explain your answers to 11 or 12, please indicate which question and the reason for your answer:

Question#	Name of Proposed Insured	Reason

AUTHORIZATION AND ACKNOWLEDGEMENT

AGREEMENT: I have read, or had read to me, the completed application. I hereby agree that: (1) I understand that no agent or other company representative is allowed to permit me to answer any questions inaccurately or untruthfully and I represent such did not occur. (2) I represent that all information shown above is correct, and having read this application

and the above statements and answer any attachments. I represent that they are true and complete to the best of my knowledge and belief, and agree that this application (and any other required parts) shall be the basis for, and a part of any policy of insurance issued. (3) If any material misstatements are made, they may be the basis for later rescission of coverage; and (4) I understand the insurance hereby applied for will not be considered in force until a policy is issued and full first premium paid while I am alive and other conditions remain and described in this application. If this application is declined and a policy is not issued, the insurer's only obligation will be to return any premium paid. **No representation by an agent or any other person shall be binding on the insurer unless such representation is reduced to writing and signed by an officer of the insurer.**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud in the application for coverage. Penalties may include imprisonment, fine, denial of insurance, and civil damages.

Check only one:
( ) This application was filled out and completed by me in my handwriting and submitted to a licensed independent agent;
( ) This application was filled out and completed by a licensed independent agent at my direction; or
( ) This application was filled out and completed by me in my handwriting and submitted to the Administrator for the State of Georgia Assignment System.

X Signature of Applicant Date	**Agent's Use Only:** Signed and Dated on ____/____/____(month/day/year) State License No: 465123
	Name (in print) Bob Vineyard Agency (if applicable)____ Address 660 Weatherly Ln City Sandy Springs State GA Zip 30328 Agent's Phone (404) 252-5859
X Signature of Spouse Date	X Agent's Signature

Glossary of Terms

The following definitions are for reference only.

Eligible: To be eligible for medical coverage does not necessarily mean that the proposed insured is actually *covered* by another medical policy. For example, if you lost group coverage following your loss of employment, you may be eligible for coverage under your spouse's plan. If you are *eligible* for other group coverage, Medicare, or Medicaid at the time of application, then you are not eligible for coverage under this assignment system. Other group coverage includes an employer health plan, your spouse's employer health plan, or through COBRA.

Self-insured plan: "Self-insured" is a method that employers use to fund their medical plan. You may not readily know if your previous coverage was self-insured or fully insured. You may find this out by either contacting your prior employer, claim administrator, or insurer, or it may be included in your medical summary plan description, evidence or certificate of coverage, or plan booklet.

Creditable coverage: Credible coverage means medical coverage with no greater than a 63-day gap in coverage under any of the following: Medicare, Medicaid, employer based health, individual health, spouse benefits or coverage, a conversion policy, true association group health coverage, Indian Health Service, a state high risk health pool plan, a public health plan, a Peace Corps Act health benefit plan. For Georgia Assignment System qualification purposes, creditable coverage may include or have included any of these, but the most recent coverage must have been group health coverage.

A child may still be eligible for coverage under this policy and not have 18 months of credible coverage if he/she satisfies certain criteria. A child is deemed an eligible individual if the following conditions are met: (1) The child was covered under the group health plan or COBRA within 31 days of birth, adoption, or placement for adoption, and (2) the child had not had a significant break in coverage of 63 days or more.

Enhanced Conversion Option or Policy: Under a group health plan that is not a self-insured plan (in other words, a group health policy), you may be eligible for benefits under an enhanced conversion option or policy. In certain cases, if your employer health plan was offered through a group health insurance policy issued to an employer in Georgia, your group insurer must offer you coverage under an enhanced conversion option or policy. Check with your prior employer or insurer to see if you are eligible for such coverage. You may not be eligible for assignment system coverage if you are eligible for an enhanced conversion option or policy.

HMO or Health Maintenance Organization/ EPO or Exclusive Provider Organization: Under an HMO or EPO, an individual must select from a list of network physicians in order to receive benefits. Typically each covered individual has a primary care physician (PCP) who manages the care of that individual. If a network physician is not used, or if proper authorization is not obtained, then benefits may not be covered, Under an HMO the individual is not usually required to file claim forms and the PCP is typically responsible for obtaining pre-authorization of treatment.

PPO or Preferred Provider Organization: A PPO allows the covered individual to select from a list of network physicians to receive greater benefits, usually in the form of lower deductibles or coinsurance percentages. If an individual opts to not use a network physician, then the service may be covered, but at a lower level of benefits. Under a PPO, an individual is not necessarily required to select a primary care physician (PCP).

Traditional Indemnity: A traditional indemnity plan provides the same level of benefits, regardless of the physician chosen; there is no distinction between in-network or out-of-network care. Under a traditional indemnity plan, the individual is typically responsible for filing claims and obtaining any necessary pre-authorization.

Do not mark beyond this point – for administrator's use only.

Application#

Comments:

Indemnity Schedule of Benefits Summary

Schedule of Benefits	Plan A	Plan B
Lifetime Maximum: The most (COMPANY) will pay for the costs of non-Emergency Services over the course of your life.	$2,000,000	$2,000,000
Calendar Year Deductible: The amount you must pay each year for covered before (COMPANY) has an obligation to pay any amount.	$2,500	$2,000
Maximum Deductible Per Family	$5,000	$4,000
Percentage Covered After Deductible Is Met: The annual maximums after which no longer have to pay for specific services.	70% of eligible benefits of first $10,000 of eligible charges; 100% thereafter.	70% of eligible benefits of first $10,000 of eligible charges; 100% thereafter.
Percentage Covered for Outpatient Treatment of Accident Injury:	70%	70%
Lifetime Maximum For Inpatient Care of Substance Abuse:	$10,000	$10,000
Treatment for Inpatient Mental Health Disorders:	30 day limit for inpatient mental health treatment, 60 day maximum per lifetime; no coverage for outpatient treatment.	30 day limit for inpatient mental health treatment, 60 day maximum per lifetime; no coverage for outpatient treatment.
Hospital Inpatient Care:	Includes semi-private room, intensive care and cardiac care services and supplies and other hospital services.	Includes semi-private room, intensive care and cardiac care services and supplies and other hospital services.
Pre-Admission Certification:	Pre-admission certification is required for all hospital admissions. Emergency or maternity care admissions must be certified within 48 hours. A $500.00 penalty may apply if you are hospitalized and pre-admission has not been obtained.	Pre-admission certification is required for all hospital admissions. Emergency or maternity care admissions must be certified within 48 hours. A $500.00 penalty may apply if you are hospitalized and pre-admission certification has not been obtained.
Length of Stay:	Unlimited as long as medically necessary, subject to maximum lifetime benefit.	Unlimited as long as medically necessary, subject to maximum lifetime benefit.
Hospice Care:	Benefits are provided for inpatient and outpatient hospice care. There is a $3,000 lifetime maximum.	Benefits are provided for inpatient and outpatient hospice care. There is a $3,000 lifetime maximum.
Outpatient Surgery:	Covered, subject to deductible, coinsurance, and maximum lifetime benefit limitations.	Covered, subject to deductible, coinsurance, and maximum lifetime benefit limitations.
Child Wellness Services:	Up through age 5. Includes age appropriate immunizations and laboratory exams. No deductible applies.	Up through age 5. Includes age appropriate immunizations and laboratory exams. No deductible applies.
Maternity:	Covered as any other illness.	Covered as any other illness.
Prescription Drugs:	Covered, subject to deductible, coinsurance, and maximum lifetime benefit limitations.	Covered, subject to deductible, coinsurance, and maximum lifetime benefit limitations.

GEORGIA HEALTH INSURANCE ASSIGNMENT SYSTEM
(INDEMNITY)

PLAN A

AGE	SINGLE MALE	SINGLE FEMALE	FAMILY
00-19	$192.50	$216.86	$446.99
20-29	$183.28	$243.31	$570.13
30-39	$233.06	$333.14	$698.34
40-49	$312.43	$410.33	$802.64
50-59	$463.10	$504.72	$995.65
60-64	$592.79	$564.88	$1,144.37
65+	$313.71	$389.80	$744.30

GEORGIA HEALTH INSURANCE ASSIGNMENT SYSTEM
(INDEMNITY)

PLAN B

AGE	SINGLE MALE	SINGLE FEMALE	FAMILY
00-19	$211.48	$238.26	$491.08
20-29	$201.35	$267.29	$626.36
30-39	$256.07	$366.00	$767.22
40-49	$343.24	$450.82	$881.79
50-59	$508.77	$554.51	$1,093.85
60-64	$651.25	$620.60	$1,257.23
65+	$344.66	$428.23	$814.05

HMO Schedule of Benefits Summary

You Are Eligible for HMO Plans C & D Only If You Live in the Atlanta Area and Were Previously Covered by an HMO – Please Contact the Plan Administrator for More Information

Schedule of Benefits	Plan C	Plan D
Annual Deductible: The amount you must pay each year for covered services before the company has an obligation to pay any amount.	Nothing	Nothing
Lifetime Benefit Maximum: The most the company will pay for the cost of non-emergency services over the course of your life.	Unlimited	Unlimited
Supplemental Charge and Co-Insurance Maximums: The annual maximums after which you no longer have to pay for specific services.	Single: $2,500 Family: $5,000	Single: $2,500 Family: $5,000
Benefits and Services	**You Pay**	**You Pay**
Outpatient Visits: Visits to physicians, consultation and treatment by specialists, lab, x-ray and other diagnostic services, medical social services, family planning, dressing, casts, catheters and catheter and ostomy supplies, allergy testing, short-term rehabilitation and physical, speech and occupational therapy, respiratory therapy. Allergy injection. Allergy maintenance serum.	$30 per visit $5 per visit $50 every 6 months	$25 per visit $5 per visit $50 every 6 months
Outpatient Surgery: Surgery at designated outpatient surgical facilities.	$100 per visit	$75 per visit
Preventive Care: Routine physical examinations, immunizations in general use, mammography, prostate cancer screening, health education, pap smears, vision and hearing screenings, contraceptive guidance. Well-child care.	$30 per visit No charge up to 2 years of age, then $30 per visit	$25 per visit No charge up to 2 years of age, then $25 per visit
In the Hospital: Physician and surgeon services including surgery, anesthesia and consultations, general nursing care, special duty nursing when prescribed, intensive care, semi-private room (private room, if medically necessary), lab, x-ray and other diagnostic services.	$500 per admission	$300 per admission
Pre-Admission Certification:	Pre-admission certification is required for all hospital admissions. Emergency or maternity care admissions must be certified within 48 hours. A $500 penalty may apply if you are hospitalized and pre-admission has not been obtained.	Pre-admission certification is required for all hospital admissions. Emergency or maternity care admissions must be certified within 48 hours. A $500 penalty may apply if you are hospitalized and pre-admission certification has not been obtained.
Prescription Drugs: Up to a 30 days' supply or the standard prescription amount of drugs and certain accessories.	$21 for prescriptions and refills	$21 for prescriptions and refills
Maternity and Related Benefits: Delivery and prenatal care and first potential visit. Postnatal visits after the first postnatal visit.	$500 per delivery $30 per visit	$300 per delivery $25 per visit
Emergency Services: In the service area – for emergencies that threaten life or health, call 911 or go to the nearest hospital emergency medical facility, regardless of whether or not it has been designated for emergency care by the company. If you feel that taking the time to call us would not jeopardize your life or health, we encourage you to call us so you can get the appropriate level of care. Plan charges are waived if admitted.	$100 per visit	$75 per visit
Mental Health: Short-term therapy.	Inpatient: $500 per admission (30 days per calendar year) Outpatient: $30 per visit; 20 visits per year	Inpatient: $300 per admission (30 days per calendar year) Outpatient: $25 per visit; 20 visits per year

Alcoholism and Drug Detoxification: Alcohol and Drug detoxification.	Inpatient: $500 per admission Outpatient: $30 per visit	Inpatient: $300 per admission Outpatient: $25 per visit
Rehabilitation: Short-term physical, speech and occupational therapy in the hospital or in an extended care facility and rehabilitation services.	Inpatient: $500 per admission Outpatient: $30 per visit	Inpatient: $300 per admission Outpatient: $25 per visit
Ambulance Service: Medically necessary ambulance service	No Charge	No Charge
Additional Benefits and Services: Dental services and appliances for accidental bodily injury to sound and natural teeth. Non-surgical dental treatment, including splints and appliances, for Temporomandibular Joint Dysfunction when medically necessary.	50% or first $1,000 and all charges thereafter 50% of all charges	50% or first $1,000 and all charges thereafter 50% or all charges
Vision: Eye exams for corrective lenses and screening for eye diseases	$15 per visit	$15 per visit

GEORGIA HEALTH INSURANCE ASSIGNMENT SYSTEM
(HMO or PSHCC)

PLAN C

AGE	SINGLE MALE	SINGLE FEMALE	FAMILY
00-19	$184.68	$208.06	$428.81
20-29	$175.84	$233.40	$546.97
30-39	$223.60	$319.60	$669.92
40-49	$299.73	$393.66	$770.03
50-59	$444.27	$484.22	$955.19
60-64	$568.71	$541.94	$1,097.86
65+	$300.97	$373.94	$714.04

GEORGIA HEALTH INSURANCE ASSIGNMENT SYSTEM
(HMO or PSHCC)

PLAN D

AGE	SINGLE MALE	SINGLE FEMALE	FAMILY
00-19	$194.68	$219.33	$452.05
20-29	$185.36	$246.05	$576.60
30-39	$235.72	$336.92	$706.28
40-49	$315.97	$415.00	$811.76
50-59	$468.34	$510.46	$1,006.95
60-64	$599.54	$571.29	$1,157.36
65+	$317.28	$394.21	$752.73

Answers To The Most Commonly Asked Questions Regarding The Georgia Health Insurance Assignment System

1) **Question:** How long do I have to submit my Assignment System application to the Insurance Commissioner's Office?
Answer: You have 63 days from the date your coverage ends for the application to be received in the Commissioner's Office. If you feel like it may not make it in time due to the mailing time involved, you can fax it to the office at (404) 657-7679. It is very important that your application be received before the 63-day period expires. Applications received after the 63-day limit will be denied.

2) **Question:** What services are subject to the deductible?
Answer: All covered services are subject to the deductible. This includes inpatient treatment, outpatient treatment, services performed in the doctor's office, and prescription drugs.

3) **Question:** If my group coverage ends and the assignment policy is not issued by the company until after my coverage ends, will I lose any coverage time?
Answer: No. This policy is retroactive. If your coverage ended on January 31 and the policy was not issued until February 18, the policy effective date would be February 1.

4) **Question:** The company I worked for was based in Georgia. The policy that covered the employee was purchased in Georgia. Should I apply for the Assignment System?
Answer: No. Since the policy is subject to Georgia Insurance Laws it will not be eligible for the Assignment System. However, you may eligible for an Enhanced Conversion Policy. Since this policy is subject to Georgia laws, your company may be required to offer this to you. The benefits for this policy are the same benefits that are offered in the Assignment System Policy. You should contact your old employer or insurance company to see if you are eligible for this coverage.

5) **Question:** What are the qualifications for coverage under the Assignment System?
Answer: In order to be eligible for coverage under the Assignment System you must meet the following guidelines: 1) You must be a Georgia resident. 2) You must have completed Cobra, if it was available. 3) The previous group plan you were covered under must have been self –insured or the policy must have been issued out of another state. 4) You cannot be eligible for any other health insurance policy, including Medicare, Medicaid, group or individual coverage. 5) The insured must have 18-months of previous creditable coverage.

6) **Question:** What is a Certificate of Creditable Coverage?
Answer: The Certificate of Creditable Coverage is supplied to you by your former employer or insurer once your coverage ends. This certificate is also led a Certificate of Group Health Coverage or a Certificate of Prior Coverage. This

certificate is used by the company to verify if you meet the requirements under the Assignment System. The certificate usually indicates the entire time you were covered by the company. In some situations you may have to supply multiple certificates to prove that you have the required 18-months of previous credible coverage. This form must be supplied in order for you to be assigned to a company. You will need to contact your former employer, insurer, or administrator if you have not received this certificate by the time you are sending your application to this office. Please remember, you cannot be assigned without a Certificate of Creditable Coverage. However, do not hold your application beyond the 63 day period while you wait for your certificate. If time is running out, you should send in your application before the 63 day period expires. You can mail or fax your Certificate of Creditable Coverage at a later date.

7) **Question:** What is Creditable Coverage?
Answer: Most health insurance coverage is Creditable Coverage. Creditable coverage includes individual health insurance, group health insurance, coverage under Cobra, Medicare, and Medicaid.

8) **Question:** Who determines the premium amount that is paid for the Assignment Policy? Will this amount ever increase?
Answer: The premium amount you pay for this policy is set by our office. Unfortunately, as the cost of health care rises, the premium for this policy may have to be increased periodically.

9) **Question:** Once my application has been submitted, how long will it be before I am assigned to an insurance company?
Answer: Once the application is received in this office you are usually assigned within 5 working days. However, due to mailing times both to our office and back to you, it can take approximately 15 working days for you to receive your letter from this office indicating which company you have been assigned to. The same could be true for your hearing from the insurance company. A good rule of thumb is that from the time your application is received in our office until the time you receive your policy from the insurance company can take approximately 30 days. Of course some applications are processed faster and some that require additional information take longer. Always remember that this policy is retroactive back to the date the group coverage ended. You should keep any claims incurred during this time so they can be sent to the insurance company once you are assigned.

10) **Question:** Due to delays in obtaining my Certificate of Creditable Coverage, my policy was not issued until 2 months after my group policy lapsed. Will I be responsible for paying the back premium that is due on my policy?
Answer: Yes. As previously stated, this policy is retroactive back to the date that your group coverage ended. In order for the policy to cover any claims that may occur during this time and to avoid any lapses in coverage, you are responsible for any back premium that is due.

11) **Question:** Should I send in my premium check with my application?
Answer: No. Do not send in your check until the insurance company you are assigned to requests that you do.