

Health Insurance

SURVIVING DEPENDENT

- I wish to continue health coverage
- I refuse coverage (complete box below and return form to Employee Benefits)

Send this completed form to:
Employee Benefits
Human Resources Bldg.
215 S. Jackson St.
Athens, GA 30602-4133

• FOR BENEFITS USE ONLY •

APPLICANT'S NAME
Last First MI Social Security Number

BILLING ADDRESS (Include city, state, zip) County

HOME ADDRESS (if different from billing address) (Include city, state, zip) Home phone (include area code)

DATE OF BIRTH Mo. Day Year	Name of deceased retiree/employee	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Widow(ed) <input type="checkbox"/> Dependent	Coverage desired <input type="checkbox"/> Applicant only <input type="checkbox"/> Applicant + child <input type="checkbox"/> Family
DATE OF DEATH OF RETIREE/EMPLOYEE Mo. Day Year	SS # of deceased			

Your premiums will be billed monthly by the University of Georgia. Payments for insurance premiums are due by the tenth of the month following the billing date.

Applicant signature

Date signed

• IMPORTANT •

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.

Information regarding the University System of Georgia healthcare plan benefits and provider networks are available at:
<http://www.usg.edu/employment/benefits/health/>

REFUSAL FORM

I DO NOT want University System of Georgia health coverage at this time. I understand I will not be able to enroll in the future.

Name _____

SS# _____

Date _____

Signature _____

Return this form to Employee Benefits

List all eligible individuals you wish to cover.

Last name	First name	Relationship	Gender	Birthdate		
				Month	Day	Year
2.		<input type="checkbox"/> SPOUSE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
		Children	Complete if child is over 19			
3.		<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
4.		<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
5.		<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
6.		<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
7.		<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			

Check here if you are eligible for Medicare:

Part A • Effective date _____

Part B • Effective date _____

Medicare HIC # _____

Check here if other dependents are eligible for Medicare:

Name _____

Part A • Effective date _____

Part B • Effective date _____

Are you or your dependents covered under any other group/employer health insurance program?

Yes No If yes, complete sections A through C below.

Please attach copies of your Medicare card if applicable.

A. Name of insurance co. (s) & employer(s)

Self _____

Dependent _____

B. Effective date(s) of policy(ies) & contract number(s)

C. Type of contract Self only Family

*Complete an "Application for Unmarried Dependent Student" form for children over age 19, available at: <http://www.busfin.uga.edu/benefits/ben2.html>

HMO ONLY

Information should correspond to the numbers of covered individuals listed above. (#1 is self; #2 is spouse; #3 is a child, etc.)

Primary Care Physician Name

Primary Care Physician ID #
(if listed at left)

1	1
2	2
3	3
4	4
5	5
6	6
7	7