CareSource
P.O. Box 1327
Dayton, OH 45401-1327

Georgia
Individual Enrollment Application

IMPORTANT: Premium payment is required for coverage requested herein to take effect. If you have anyquestions while completing this application, please call 844-539-1733.

Please complete in blue or black ink only. All questions must be completely answered in order for your application to be processed.

Section A - Coverage Information

Application Type (select one):

☐ New Coverage

☐ Change policy coverage Policy No: _____

☐ Add dependent(s) to current coverage Policy No. _____

OPEN ENROLLMENT

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. Open Enrollment begins November 1 and ends January 15. The earliest Effective Date for the annual Open Enrollment period is the first dayof the following calendar year. Open Enrollment applications received after January 15 will be rejected.

Please check the box below if you are seeking to enroll in CareSource as part of Open Enrollment.

☐ I am enrolling as part of Open Enrollment.

Section B - Applicant Information

Last Name	First Name	MI	Social Security Number
Home Address			
City	State	ZIP	County
Billing Address (street and P.O. Box if applicable)			
City	State	ZIP	
Marital Status ☐Single ☐Married	Sex ☐M ☐F	Date of Birth / /	
Primary Phone Number ( )	Secondary Phone Number ( )	E-mail	

☐ Applicant does not seek coverage, is instead applying on the behalf of a dependent or ward. **By checking this box, the applicant will not be covered on this plan.**

Section C - Spouse or Domestic Partner to be Covered

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner
Social Security Number	Sex ☐M ☐F	Date of Birth / /	

Section D - Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent includes, to the end of the benefit year in which they turn age 26 years old, any natural blood related children, stepchildren, legally adopted children, a child for whom you have legal custody of or guardianship, or a child who is entitled to coverage under the plan because of a medical support order. In addition, if your dependent child is over 26 years old, but incapable of self-sustaining employment by reason of development or intellectual disability or physical handicap and is primarily dependent on you, then such dependent child will be considered an eligible dependent. A subscriber has the option to cancel dependent coverage effective on the next available date after notice is received by CareSource. (List all dependents beginning with the eldest.)

Last Name	First Name	MI	Sex	Date of Birth mm/dd/yyyy	Social Security Number	Relationship toApplicant
			☐ M ☐ F	/ /		☐ Child ☐ Other:
			☐ M ☐ F	/ /		☐ Child ☐ Other:
			☐ M ☐ F	/ /		☐ Child ☐ Other:
			☐ M ☐ F	/ /		☐ Child ☐ Other:____

Section H – Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare or have a condition which would qualify you for Medicare (e.g., End Stage Renal Disease (ESRD or Amyotrophic Lateral Sclerosis (ALS))?

☐ Yes ☐ No

Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits?

☐ Yes ☐ No

If Yes to either of the above questions, please identify who, the reason for the yes, and dates for the benefit/coverage below:

_____

_____

Start date of other benefits/coverage: _____/_____/_____

End date of other benefits/coverage: _____/_____/_____

Do you or anyone applying for coverage currently have health care coverage? ☐ Yes ☐ No

If **YES**, please provide the following:

Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name(s) and phone numbers of other carrier(s):		
Type of coverage:		Effective date of coverage
☐ Group	☐ Individual	

Will you be cancelling this coverage if approved for CareSource coverage? ☐ Yes ☐ No

If **YES**, what is the cancellation date? _____

Section I – Race/Ethnicity – Your response is appreciated but not required.

Choose a category that most closely describes you:

☐ American Indian or Alaskan native
☐ Asian or Pacific Islander
☐ Black, not of Hispanic origin
☐ White, not of Hispanic origin
☐ Hispanic

Your language of preference: _____

Section J – Acknowledgments and Significant Terms and Conditions (TERMS)

- Each individual age 18 or older listed on this application acknowledges the following: I have provided true and complete answers to all questions in the application to the best of my knowledge and understand that all answers are important and will be considered by CareSource in the acceptance or denial of this application. I acknowledge I have read and understand the TERMS and have agreed to be bound by all the Terms stated in this application, to the extent applicable.
- The primary applicant additionally acknowledges the following: My spouse/domestic partner, if listed, and all of my dependents listed on this application who are 18 years of age or older have read this application and have provided complete and accurate information for this application to the best of my knowledge. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure that all information about all applicants, including my children under the age of 18, listed on this application is true and complete.
- I acknowledge that I have read and understand the TERMS and accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by CareSource in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission, or cancellation of my coverage(s).

Pediatric Dental Coverage

Dental Coverage for children under 19 years of age is considered an Essential Health Benefit and we are required to confirm that everyone applying has coverage through an exchange certified stand-alone dental plan.

- ☐ I attest that I have purchased an exchange certified stand-alone dental plan for anyone under 19 years of age on this application.
- ☐ There is no one under 19 years of age on this application.

I am making this application and requesting coverage for myself and my spouse/domestic partner and dependents if named in this application. I am acting as their agent and representative to the extent permitted by applicable federal and state law.

This application shall only be altered by the applicant or with his or her written consent.

SIGN HERE	Signature of Applicant or Legal Representative (If legal representative, please state your relationship)	Date
SIGN HERE	Signature of Spouse/Domestic Partner	Date
SIGN HERE	Signature of Dependent Over 18	Date
SIGN HERE	Signature of Dependent Over 18	Date

Section K – Agent Information (Please complete if applicable)

Agent Information

Complete this section if an agent assisted you in filling out this application and selecting a policy. CareSource will not engage directly with any Agent unless properly authorized by you.

Agent Name:_____ Agent Phone:_____

Agency:_____ Address:_____ Producer #: _____

Applicant Signature:_____ Date:_____

A photocopy or electronic representation of this form will be as valid as the original. You or an authorized representative have the right to receive a copy of this Authorization upon request.

THANK YOU FOR APPLYING.

PLEASE INCLUDE ALL NECESSARY MATERIALS WHEN SUBMITTING THE APPLICATION.

IF YOU ARE A LEGAL GUARDIAN AND APPLYING FOR COVERAGE FOR THE INDIVIDUAL YOU HAVE GUARDIANSHIP OVER,PLEASE INCLUDE THE APPROPRIATE LEGAL DOCUMENTATION SHOWING GUARDIANSHIP.