



Thank you for choosing us to be your Blue Cross Blue Shield of Georgia Agent of Record. Judy and I promise to take very good care of you!

Please complete the following ASAP so we may start the process. The information must be based on the PRIMARY policyholder.

Watch for the Arrows and "X"s!

1. **Page 1 – Complete the first three lines, sign and date.**
2. **Page 2 – Complete the middle section only.**
3. **Page 3 – Sign and date.**
4. **If possible, make an enlarged copy of your ID card.**
5. **Fax back to 770-967-0372. No cover page needed.**

If any of this is too much trouble, just sign the two forms and fax back. We can do the hard parts. I will be watching for the forms to be returned.

Best regards,

Jerry Brackett

Brackett Consultants Inc. dba

Brackett Insurance Consultants

Telephone 770-967-1111 ♦ Toll-free 1-877-967-4732 ♦ Fax 770-967-0372

Post Office Box 1105, Buford GA 30515

Info@ThePolicyHunters.com



Agent of Record Change Request Form For Blue Cross Blue Shield of GA Individual Health Plans

This form shall serve as a request by the Blue Cross Blue Shield of Georgia Individual Health Plan Policy member, indicated below, to change from the current agent to the new agent named below for the purpose of commissions payable on the policy and servicing duties to the policy holder.

Completed form (accompanied by signed "Authorization to Release PHI" Form) must be received by BCBSGA by the 15th of the month in order to be effective the first of the following month.

By completing and submitting this AOR Change Request Form, the policy holder understands that this agreement will terminate the commissions payable and the servicing duties of the original writing agent, and further, that the terminated agent will receive notification from BCBSGA of termination of his/her services as well as commissions payable on the policy holder's contract as of the effective date of this Agent of Record Change Request. The member's contract must be in force no less than 12 consecutive months, and AOR changes may only be made one time in a 12 month period.

The new agent agrees that he/she has been licensed with BCBSGA at least 12 consecutive months and has had at least 50 new Individual BCBSGA contracts approved in the prior calendar year. Further, this agent agrees that AOR contracts are paid at 5% commission, and contracts received via AOR change do not apply to BCBSGA agent sales production or bonus incentives.

Policy Holder completes the following:

→ Policy Holder Name: _____

→ Policy Holder SSN or Policy Number: _____

→ Policy Original Effective Date: _____

New Agent Name: Jerry Brackett BCBSGA Rep# 10804

Reason for Termination of in-force agent: _____

Prefer to use the services of
Jerry Brackett

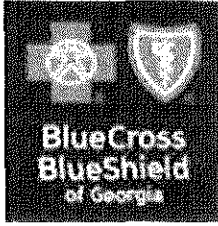
X Signature of Policy holder: _____ Date: _____

Signature of New Agent: Jerry Brackett Date: _____

Agent Email Address: Jerry@GeorgiaInsurance.info Phone#: 770-967-4732

**Fax completed form with PHI form to: Blue Cross Blue Shield of Georgia
Consumer Services
404-682-3233**

(Internal Use Only below this line)



Authorization for Use or Disclosure of Protected Health Information (PHI)

Please print clearly and use only black ink.

- 1. Small Group
(2-50 employees)
 - 2. Large Group
(More than 50 employees)
 - 3. Individual Coverage

*Please refer to the instructions and
check one of the above blocks.*

By completing this form, I authorize Blue Cross and Blue Shield of Georgia (BCBSGA), its agents or subsidiaries, to use or disclose my Protected Health Information (PHI) for the purposes stated on this form.

I have the right to revoke this authorization at any time by giving written notice of my revocation to BCBSGA. I understand that my revocation will not affect any action taken before my written revocation notice is received. I also understand that PHI used or disclosed under the provisions of this authorization may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule.

Part A: Please complete the following information exactly as it appears on your member Identification (ID) Card. If you are a new member and do not yet have a member ID card, please complete as much information as possible. If necessary, please contact your Employee Benefits Administrator, the Broker / Agent servicing your policy, or a BCBSGA Customer Care Associate for assistance.

<i>Member Last Name</i>	<i>Member First Name</i>	<i>Middle Initial</i>	<i>Suffix</i>
<i>Member ID Number (From ID Card)</i>	<i>Social Security Number</i>	<i>Date of Birth (mm/dd/yyyy)</i>	<i>Daytime Telephone</i>
<i>Street Address</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
<i>Employer Group Name</i>	<i>Employer Group Number</i>	<i>Member Home Fax (Optional)</i>	
If you are covered under another BCBSGA Healthcare Policy, please complete the following blocks.			
<i>Other Employer Group Name</i>	<i>Other Employer Group Number</i>	<i>Member ID Number (From other Member ID Card)</i>	

Part B: I authorize the following persons, classes of persons or entities, to receive my Protected Health Information (PHI). You should check only those blocks that apply to your needs or situation. Please refer to the instructions if you have any questions.

<input type="checkbox"/> My Spouse (Enter Name)	<input checked="" type="checkbox"/> The Agent/Broker or Insurance Agency servicing my policy <i>Brackett Insurance</i>
<input type="checkbox"/> My Domestic Partner (Enter Name)	<input type="checkbox"/> My Employee Benefits Administrator (applicable <u>only</u> if you are covered by a Group Policy)
<input type="checkbox"/> My Adult Children (Enter Name(s))	<input type="checkbox"/> Other Authorized Representative (Enter Name)
<input type="checkbox"/> My Parents (if you are over 18) (Enter Name(s))	<input type="checkbox"/> Other Authorized Representative (Enter Name)

Part C: I authorize the following Protected Health information to be used or disclosed on my behalf. Please check all blocks that apply.

Member ID Number _____
(Enter your Social Security Number if you do not have a member ID Number)

<input checked="" type="checkbox"/> All information regarding my health coverage or treatment received (<i>see instructions</i>)	<input type="checkbox"/> Benefits information
<input type="checkbox"/> All claims and payment information	<input type="checkbox"/> Billing information
<input type="checkbox"/> Appeals information	<input type="checkbox"/> Eligibility and enrollment information
<input type="checkbox"/> Psychotherapy notes (* refer to the note listed below prior to checking this block)	<input type="checkbox"/> Other (List)

* By law, an authorization to release psychotherapy notes cannot be combined with any other authorization. If this authorization is for psychotherapy notes, you must complete a separate authorization for any other type of PHI you want released.

Part D: Purpose of this authorization. Please check **ONLY ONE** of the following blocks.

<input checked="" type="checkbox"/> This authorization allows BCBSGA to respond to all requests, questions or transactions involving my health coverage or status received from the persons or entities designated in Part B above.
<input type="checkbox"/> This authorization allows BCBSGA to respond to all requests, questions or transactions involving my health coverage or status received from the persons or entities designated in Part B above for <i>only</i> the following purposes (list):

Part E: Expiration Date. (*See instructions*).

This authorization will expire upon the end of my coverage with Blue Cross and Blue Shield of Georgia or on the date specified below.

This authorization will expire on _____ (mm, dd, yyyy)

Part F: I have read the contents of this authorization and understand and agree to the use and disclosure of my Protected Health Information as specified above. I also understand this authorization is voluntary and that it will not condition my enrollment in a health plan, eligibility for benefits or payment of claims.

Date: _____

(Member Signature)

Designated Legal Representative / Guardian

If this form is signed by a legal representative / guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the ability of the legal representative to act on the individual's behalf, must be attached.

Legal representative (print full name): _____

Legal relationship to individual: _____

Signature: _____ Date: _____

Your Completed Forms

Completed forms should be faxed or mailed to the address shown below. *This form cannot be submitted by EMAIL.* Failure to provide all necessary information will result in the form being returned to you. If you require assistance, please contact BCBSGA at the number shown on your ID card.

Please FAX to (404) 842-8040 or mail to Blue Cross Blue Shield of Georgia, ATTN: Membership & Billing Department (Mail Code G00502), P.O. Box 4445, Atlanta, GA 30326

Please Keep a Copy of this Authorization Form for your Records
A copy will be provided upon your request