PLUS+ insurance
GDAplus.com

GDIS

GDA
Georgia Dental
ASSOCIATION
Endorsed By

2023 Enrollment Form

For Coverage Effective January 1, 2023

Please **FAX** completed form to: **(404) 634 6099** or **EMAIL** to: christy@gadental.org

Part 1: General Information – Please Print Legibly

Name of Dentist		**GDIS Group ID Billing#**	
(Applicant) Last Name	**First Name**		**Middle Initial**
(Applicant) Mailing Address			
City	**State**	**Zip Code**	**Hire Date**
Cell Phone #	**Business Phone #**	**Email**	
Preferred Receipt of Monthly Statement:	☐ **Email**	☐ **Regular Mail**	

Part 2: Medical Coverage – Please select your choice:

☐ **Enroll** (Complete parts 2, 3, & 4) ☐ **Cancel-Effective Date:** _____ (Sign & Date Below)
(Date must be last day of the month)

☐ **Waive** coverage (Must state reason for waiver. Sign & Date Below)

Reason for Waiver: _____

Part 2a: Medical Coverage – Please select your plan:

Effective Date: _____

☐ **POS 1000 Plan** ☐ **POS 3000 Plan** ☐ **POS HDHP**

Part 2b: Vision Coverage – Blue View Vision (Optional Coverage)

☐ **Blue View Vision Plan**

Part 3: Applicant and Covered Dependent Information

	Add	Drop	Name (Last, First, MI)	SSN	DOB	Male	Female
Applicant							
Spouse							
Child							
Child							
Child							

Part 4: Authorization (It is a Federal Crime to knowingly provide false information on a medical coverage application)

I REQUEST COVERAGE UNDER THIS GROUP PLAN. I have completed the information in this form. I understand that enrollment in this plan is subject to all the terms of the group plan, and that to be eligible, I must (a) be employed by the named employer in a class eligible for the coverage and (b) engaged in and performing the normal duties of such employment on a regular basis for at least the minimum number of hours per week (excluding duties performed at my residence while confined in a hospital). I also understand that coverage will not become effective for me or any eligible dependent until all the applicable eligibility requirements of the group plan are met. Additionally, by signing below, I authorize the use of my cellular phone number to be used for text message updates from Georgia Dental Association.

- I understand that coverage will not be effective unless I satisfy the conditions on this form.
- I understand that inaccurate answers to the questions on this enrollment form may void my coverage under this plan.

I hereby acknowledge that Blue Cross and Blue Shield of Georgia/Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSGA/BCBSHP) has informed me of the following prior to my enrollment in their health care coverage plan: a. number, mix, and location of participating/network health care providers; b. limitations on choices of participating/network health care providers; c. disclosure of contractual relationship between participating/network provider and BCBSGA/BCBSHP.

Applicant's Signature _____ **Date Signed** _____