GEORGIA BANKERS ASSOCIATION INSURANCE TRUST, INC.
ANNUAL ENROLLMENT FORM EFFECTIVE JANUARY 1, 2022

This form should be completed by active employees not currently covered under the medical and/or dental plan or making changes for themselves and/or their eligible dependents enrolling under the Annual Enrollment Period for January 1, 2022.

EMPLOYER (COMPANY) NAME: Pinnacle Bank | EMPLOYER CITY: Elberton | BANK NUMBER:

EMPLOYEE NAME - FIRST | MI | LAST

EMPLOYEE SOCIAL SECURITY NUMBER ___ - ___ - ____

Phone Number: _____ Email Address: _____

REQUESTING COVERAGE FOR:

- ☐ **EMPLOYEE** ☐ **CHANGE PLAN TO:**
- ☐ **ADD EMPLOYEE MEDICAL COVERAGE**
- ☐ **ADD EMPLOYEE DENTAL COVERAGE**
- ☐ **TERMINATE EMPLOYEE MEDICAL**
- ☐ **TERMINATE EMPLOYEE DENTAL**

- ☐ **PPO PLAN #** 290 **(250, 280, 290, 295, 780, or 781)**
- ☐ **HMO PLAN #** 620 **(610,or 620)**
- ☐ **POS PLAN #** **(450, 480, 490, 495, 481, or 482)**

☐ **SPOUSE** ☐ **ADD MEDICAL** ☐ **ADD DENTAL** ☐ **TERMINATE MEDICAL** ☐ **TERMINATE DENTAL**

SPOUSE ☐ M ☐ F — LAST NAME | DATE OF BIRTH (MM-DD-YYYY) | FIRST NAME | MI | SOCIAL SECURITY NUMBER

☐ **CHILDREN** ☐ **ADD MEDICAL** ☐ **ADD DENTAL** ☐ **TERMINATE MEDICAL** ☐ **TERMINATE DENTAL**

CHILD 1 ☐ M ☐ F — LAST NAME | DATE OF BIRTH (MM-DD-YYYY) | FIRST NAME | MI | SOCIAL SECURITY NUMBER | Disabled ? ☐ Y ☐ N

CHILD 2 ☐ M ☐ F — LAST NAME | DATE OF BIRTH (MM-DD-YYYY) | FIRST NAME | MI | SOCIAL SECURITY NUMBER | Disabled ? ☐ Y ☐ N

CHILD 3 ☐ M ☐ F — LAST NAME | DATE OF BIRTH (MM-DD-YYYY) | FIRST NAME | MI | SOCIAL SECURITY NUMBER | Disabled ? ☐ Y ☐ N

CHILD 4 ☐ M ☐ F — LAST NAME | DATE OF BIRTH (MM-DD-YYYY) | FIRST NAME | MI | SOCIAL SECURITY NUMBER | Disabled ? ☐ Y ☐ N

I understand that this coverage will become effective January 1, 2022. I hereby apply for Group Insurance for which I am or may become eligible under the group policy (ies) issued to my Employer through Georgia Bankers Association Insurance Trust, Inc. and authorize the deductions from my earnings (if contributory) of the amount required to cover my share of the premiums.

SB476 Acknowledgement

I understand that I am enrolling in a health care plan, which requires that health care services must be provided by participating providers. Failure to use a participating provider will result in reduced coverage or no coverage for services that I receive, and I will be fully responsible for any and all costs not covered by Blue Cross and Blue Shield of Georgia/Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSGA) (as applicable).

I have received a complete listing of participating providers. I understand that the participation status of any provider may change from time to time. It is my responsibility to verify that my health care provider is participating with BCBSGA/BCBSHP prior to receiving services. I may verify participation status via BCBSGA's Web site, www.anthem.com which is updated at least every 30 days. I may also verify status by contacting the customer service number listed on my member ID card.

As required by the State of Georgia regulations, the following is a summary of the financial arrangements with the health care providers who are participating in the BCBSGA/BCBSHP network:

1. Hospital providers are paid according to a contract which includes inpatient per diems, case rates, and discounted fee for service arrangements depending on specific services provided.
2. Physicians are paid discounted fee for service in accordance with a specific fee schedule, which has been provided to them as contracted.
3. Laboratory services are provided through a capitated per member per month flat fee.
4. Other ancillary services including home health, skilled nursing, and hospice are paid on a contracted fee schedule with per diems or per visit amounts

EMPLOYEE'S SIGNATURE - REQUIRED _____ DATE _____