



**Section A: Current Information**

Group Name:	Group #:	Division #:	Package #:
Employee Name: (Last, First Name, M.I.)	Social Security #:	Effective Date of Coverage:	Date of Event:

**Section B: Coverage Change Information**

Reason for Change:	<input type="checkbox"/> Adoption	<input type="checkbox"/> Death	<input type="checkbox"/> Leave of Absence/Layoff	<input type="checkbox"/> Moved from Service Area
	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Section 125	<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth
	<input type="checkbox"/> Over-Aged Dependent	<input type="checkbox"/> Terminate Employment	<input type="checkbox"/> Return of Alternate Insurance	<input type="checkbox"/> Loss of Coverage
	<input type="checkbox"/> Divorce	<input type="checkbox"/> Location _____	<input type="checkbox"/> Employee # _____	<input type="checkbox"/> Other _____
Change Request Type:	<input type="checkbox"/> New Name:			<input type="checkbox"/> New Physician Name/ID:
	<input type="checkbox"/> New Address:			<input type="checkbox"/> New Phone #:

Plan Coverage Type Requested:  Add Health  Delete Health  Change Plan: *Indicate Plan #*

Coverage Level Requested:  Employee  \*Employee & Spouse  \*Employee & One Dependent  \*Employee & Children  Family  
\* When available

Dependent Change *Complete Section C*  Other Change:

**Section C: Dependent Information** *Attach separate sheet, if additional space is needed, with dependent information, sign & date.*

Last Name: <i>(if different than employee)</i> First Name, M.I.	Social Security Number:	Birth Date:	Relation to You					Physician Name/ID <i>HMO only</i>	Existing Patient (Y/N)	Dependent			Ethnicity <i>optional</i> <i>Circle all that apply.</i>					
			Spouse (S)	Child (C)	Other (O)*	Sex (M or F)	Check if Disabled			You Support	Lives With You	Is a Student	A)	B)	C)	H)	N)	W)
									<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A	B	C	H	N	W
									<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A	B	C	H	N	W
									<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A	B	C	H	N	W
									<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A	B	C	H	N	W

List the name of each dependent listed above that is married or has dependent child(ren) or lives outside of Florida.

\* If you indicated "O" in "Relation to You" above for any dependents, please explain here:

**Section D: Other Health Insurance Information** *This section must be completed for claims processing and Prior Coverage Information*

In addition to this policy, do you or your dependents have any other insurance coverage (including BCBSF plans) that will be in effect after this coverage begins?  Yes  No

BCBSF Contract # \_\_\_\_\_ Medicare # \_\_\_\_\_ Pharmacy /Medicare D # \_\_\_\_\_

Complete the following only if this is the first time you or your dependents: (1) are enrolling for health insurance with this employer; (2) currently have health coverage; and/or (3) have any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable Coverage.

Prior Health Carrier Name:	Contract #:	Effective Date:
Prior Employee Hire Date:	Cancel Date:	List names of all family members that were covered, including yourself:
Employee Signature:	Date:	
Employer Signature:	Date:	

## Section E: Change Authorization

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### Plan Coverage Terms

I hereby authorize the changes to my Blue Cross Blue Shield of Florida, Inc. ("BCBSF") and/or Health Options, Inc. ("HOI") contract that is selected on this form. I understand and agree that the changes will not be effective until this application is accepted by BCBSF and/or HOI.

I authorize my employer to deduct from my earnings my premium contribution, if any, including any additional amounts required as a result of the changes indicated on this Health & Financial Change Application. I understand all of the following:

1. If my coverage/membership is to be issued and continued, I must meet all the group contract's requirements;
2. If my dependents' coverage/membership, if any, is to be issued and continued, my dependents must meet all the group contract's requirements;
3. If I must pay part or all of the premium, coverage/membership shall not become effective until BCBSF and/or HOI accepts this application and assigns an effective date.

I understand that membership granted to persons herein shall be subject to all provisions and limitations of the group contract. I am aware that a change in coverage of dependents may affect the amount deducted from any wages (if any) for coverage/membership, and I hereby authorize such a change.

If I am enrolling in a high-deductible health plan designated for use with a Health Savings Account (HSA) under Internal Revenue Service Code section 223, I recognize and authorize BCBSF to exchange certain limited information obtained from this application with its preferred financial partner(s) for the purposes of initial enrollment in, and administration of, HSAs.

I understand that if I am enrolling in an HSA qualified High Deductible Health Plan and I elect to receive Prior Carrier Credit under Florida law, my plan may no longer qualify as an HSA compatible plan.

### General Terms

I AGREE that in the event of any controversy or dispute between BCBSF and/or HOI, I and my dependents must exhaust the appeal and/or grievance processes in the benefit/member handbook issued to me.

I understand that my employer is not an agent of BCBSF and/or HOI. I also understand that my employer is responsible for notifying all employees of:

1. Effective dates;
2. All termination dates;
3. Any conversion, COBRA or ERISA rights or responsibilities; and
4. All other matters pertaining to coverage/membership under the group contract.

When an overpayment is made, I authorize BCBSF and/or HOI to recover the excess from any person or entity that received it.

I acknowledge that BCBSF and/or HOI coverage/membership is contingent upon the complete, accurate disclosure of the information requested on this form.

I acknowledge that, if I apply for BCBSF and/or HOI coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period. I acknowledge that any applicable credit toward a health care Pre-existing Condition Exclusion Period is contingent upon the complete and accurate disclosure of information.

I represent that the statements on this application are true and complete to the best of my knowledge and belief.

I understand and agree that misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the group contract's terms and conditions.

If applying for Miami-Dade Blue, I understand there is no participating provider network outside of Miami-Dade County. I will be responsible for all charges that exceed BCBSF's payment amount for services received from non-participating providers.