



Open Enrollment

Section A: Current Information

Group Name: Alachua County
Group #: 98621
Division #:
Package #:
Employee Name: (Last, First Name, M.I.)
Social Security #:
Effective Date of Coverage: 10/01/26
Date of Event:

Section B: Coverage Change Information

Reason for Change:
Adoption, Open Enrollment, Over-Aged Dependent, Divorce, Death, Section 125, Terminate Employment, Location, Leave of Absence/Layoff, Marriage, Return of Alternate Insurance, Employee #, Moved from Service Area, Birth, Loss of Coverage, Plan Type, etc.
Change Request Type:
New Name, New Address, New Phone #, New Physician Name/ID
Plan Coverage Type Requested:
Add Health, Delete Health, Add Vision, Delete Vision, Change Plan
Coverage Level Requested:
Employee, Employee & Spouse, Employee & One Dependent, Employee & Children, Family
Other Change:

Applicable to Group Administrator: The Affordable Care Act prohibits rescissions; cancellations cannot be submitted for the period in which a premium is collected.

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

Table with columns: Last Name, Social Security Number, Birth Date, Relation to You, Plan Type, Sex, Check if Disabled, Physician Name/ID, Existing Patient, Dependent (You Support, Lives With You, Is a Student), Ethnicity.

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 Florida Blue and/or Truli for Health plans) that will be in effect after this coverage begins?
Florida Blue and/or Truli for Health 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

Plan Coverage Terms

I hereby authorize the changes to my Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue, Health Options, Inc., DBA Florida Blue HMO and/or BeHealthy Florida, Inc. DBA Truli for Health contract that is selected on this form. I understand and agree that the changes will not be effective until this application is accepted by Florida Blue, Florida Blue HMO and/or Truli for Health.

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 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 Florida Blue, Florida Blue HMO and/or Truli for Health 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 Florida Blue and/or Truli for Health 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 Florida Blue, Florida Blue HMO and/or Truli for Health, 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 Florida Blue, Florida Blue HMO and/or Truli for Health. 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 Florida Blue, Florida Blue HMO and/or Truli for Health to recover the excess from any person or entity that received it.

I acknowledge that Florida Blue, Florida Blue HMO and/or Truli for Health coverage/membership is contingent upon the complete, accurate disclosure of the information requested on this form.

I acknowledge that, if I apply for Florida Blue, Florida Blue HMO and/or Truli for Health coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period.

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.

I understand that a copy of the Summary of Benefits and Coverage (SBC) can be obtained by contacting my Group Administrator.

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature:

Date: