

Employee Change ApplicationPlease type or write clearly in black or blue ink.

An Independent Licensee of the Blue Cross and Blue Shield Association

Section A: Curr	rent Inform	ation																				
Group Name: Group #:								Division #:						D Package #:								
Employee Name: (Last, First Name, M.I.)							Soc							ective Date of Date of Everage:						vent:		
Section B: Cov	erage Cha	ange Informatio	n										,		<u> </u>							
Reason for Adoption Death Change: Open Enrollment Section 125 Dover-Aged Dependent Terminate Divorce Employment								□ Marriage □ B □ Return of Alternate □ Lo □ Insurance □ P						Noved from Service Area irth oss of Coverage lan Type: PPO, HMO, RX)								
Change Request Type:	□ New Name:								New Physician Name/ID:													
Request Type.	□ New Address:								New Phone #:													
Plan Coverage T □ Change Plan:		sted: 🗆 Add Hea an #	ılth □De	elete F	lealth	n E] Ad	d Vi	sior	1	□ D	elete Vision	•									
Coverage Level *When available		□ Employee □	*Employe	e & Sp	ouse	· 🗆	*Em	ploy	/ee	& C	One I	Dependent	: 🗆*[Ξmp	oloy	'ee	& Cl	nildre	∍n	□F	ami	ily
□ Dependent Change Complete Section C □ Other Change:																						
which a premiur	n is collecte	nistrator: The Afford ed. By submitting fter the requeste	cancellati	ion(s) y	ou re																	′
Section C: Dep	pendent In	nformation Atta	ch separa	te she	et, if	addi	tion	al sp	oac	e is	nee	ded, with a	lepen	der	nt in	fori	mati	on, s	sign	anc	l da	ite.
Last Name: (if different than er First Name, M.I.	mployee)	Social Security Numbe	er: Birth D	rth Date: Relation to You (S) esnods *(C) July 100				Weien ad a Sex (M or F) Check if Disabled			Physician Name/ID HMO only		<u>.</u>	Dependent Ethnicity optional Circle all that apply A) Asian/Pacific Islande B) Black/African Americ C) Caribbean Islander H) Hispanic N) Native American W) White			der					
																	A		С	H	N	W
				_													A		С	H 	N	
																	A		C C	H H	N N	W
List the name o	of each dep	endent listed ab	ove that	is mar	ried	or ha	as d	epe	nde	ent	child	d(ren) or liv	es ou	ıtsic	de c	of F	lorio	da.				
* If you indicate	ed "O" in "	Relation to You'	' above fo	or any	depe	ende	ents,	, ple	ease	e ex	крlаі	n here:										
Section D: Oth	ner Health	Insurance Infor	mation T	nis sec	tion r	nust	be	com	ple	ted	l for a	claims proc	essing	g <mark>an</mark>	d P	rio	r Co	vera	ge	Info	rma	ation
In addition to the effect after this of Florida Blue Cor	coverage be	egins? □Yes □	No																that	will	l be	e in
(2) currently have attach a Certific	e health co ate of Cred	ly if this is the firs verage; and/or (3 litable Coverage oplication contain	3) have an . Any pers	y heal [.] son wh	th co no kn	vera owin	ge i Igly	n th and	e p wit	ast th ir	12 n ntent	nonths that t to injure,	t this defra	cov ud,	era	ge dec	repl eive	aces any	OR inst	yoʻl urer	ı ca file	an es a
Prior Health Carrier Name								Contract #:						E	Effective Date:							
Prior Employee Hire Date: Cancel Date:							List names of all family members yourself:								t w	ere	COV	erec	l, in	cluc	ding	9
Employee Signature:												D	Date:									
Employer Signature:											Date:											
22411-0813																						

Section E: Change Authorization

Plan Coverage Terms

I hereby authorize the changes to my Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue and/or Health Options, Inc., D/B/A Florida Blue HMO 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 and/or Florida Blue HMO.

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

I acknowledge that Florida Blue and/or Florida Blue HMO 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 and/or Florida Blue HMO 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.

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:			

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.