

## **Employee Change Application**Please 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 #:				Package				је	<del>;</del> #:				
Employee Name: (Last, First Name, M.I.)								Soc	cial	Sec	urity	y #:		Effective Date of Coverage:					Date of Event:				
Section B: Cov	erage Cha	ange Informatio	on n																				
Reason for E Change: E E	□ Termina	l Section 125 □ N l Terminate □ R Employment Ir					Marriage E Return of Alternate E Insurance E					Moved from Service Area Birth Loss of Coverage Plan Type: ex. PPO, HMO, RX)											
Change Request Type:	□ New Name:								١	New Physician Name/ID:													
nequest type.	□ New Address:								New Phone #:														
Plan Coverage T □ Change Plan:		sted: 🗆 Add Hea an #	alth □ De	elete I	Hea	alth		] Ac	ld V	isio:	n	□ Delete Vision											
Coverage Level *When available		□ Employee □	l*Employe	e & Sı	pou	ıse		*Em	plo	yee	& (	One Dependent	□*	Emı	ploy	/ee	& C	) Lhi	ldrer	۱ 🗆	Fai	mily	
□ Dependent Change Complete Section C □ Other Change:																							
which a premiur	n is collecte	nistrator: The Affe ed. By submitting fter the requeste	g cancellation	on(s)	yoı	ı re																	
Section C: De	pendent Ir	nformation Atta	ich separat	te she	eet,	if a	nddi	ition	al s	рас	e is	needed, with d	epen	dei	nt ir	nfor	mai	tio	n, siç	gn ai	nd	date	
Last Name: (if different than ei First Name, M.I.	mployee)	Social Security Number	er: Birth D	)ate:		child (C) blind	ou *_	Ту	Vision Vision	Sex (M or F)	Check if Disabled	Physician Name/ID HMO only	Existing Patient (Y/N)	You Support   G	Lives With You	a Student	A) B) C) H) N)	As Bla Ca His Na	nicity optional cle all that apply. Asian/Pacific Islander Black/African American Caribbean Islander Hispanic Jative American White				
																	Α	-	ВС	Н	1	N N	Ν
																	Α	-	ВС	Н	1	V V	N
																	Α	-	ВС	Н	1	V V	N
																	Α		ВС	Н	1	V V	N
List the name o	of each dep	endent listed ak	oove that i	is ma	rrie	d o	or ha	as d	ере	end	ent	child(ren) or liv	es ou	utsi	de (	of F	-lori	ida	Э.				_
* If you indicate	ed "O" in "	Relation to You	" above fo	or any	/ de	epe	nde	ents	, pl	ease	e ex	xplain here:											
Section D: Oth	er Health	Insurance Infor	mation T∤	nis sed	ctio	n m	nust	t be	con	nple	etec	d for claims proce	essing	g <b>ar</b>	nd F	rio	r C	ov	erag	e In	for	mati	on
In addition to the effect after this contact the state of	coverage b	egins? □Yes □	No									0					•	lar	าร) th	ıat w	<i>i</i> ill l	be ir	1
Florida Blue Cor																		_			_		_
Complete the fo (2) currently have attach a Certific statement of cla	ate of Cred	litable Coverage	e. Any pers	son w	ho	knc	owir	ngly	and	ıw b	th II	ntent to injure, c	detra	ud,	or (	ded	ceive	e a	any II	nsure	er t	ıles a	а
Prior Health Carrier Name								(	Contract #:					Effective Date:									
Prior Employee Hire Date: Cancel Date: List								st names of all family members tourself:						nat were covered, including									
Employee Signature:										С	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., 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.