



Enrollment Start with Section B. **Change in Coverage or Personal Information** Start with Section A.

Termination or Refusal of Any / All Coverage Complete Section B # 1-3. Sign and date below.

Check all coverage selections below that are being terminated or refused. I understand that if I decide to apply at a later time, that coverage may not be available until the next open enrollment or special enrollment period.

Health Dental Life Disability Voluntary Life Voluntary Disability Other

Signature of Applicant/Employee Date

The gray area below is to be completed by the Employer.

| | | | | | | | |
|--|--|--|----------------------|---|--|--|----------------------|
| Employer Group Name <input type="text"/> | | | | | Open Enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Health: Group # | Division # | Dental: Group # | Division # | Class # | Life: Group # | Division # | Class # |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date of Hire <input type="text"/> | Effective Date <input type="text"/> | Retirement Date (if retired) <input type="text"/> | | Employee # <input type="text"/> | Location # <input type="text"/> | | |
| Work Status: <input type="checkbox"/> Actively at Work <input type="checkbox"/> Retired | | <input type="checkbox"/> COBRA | | Work Hrs. Weekly: <input type="text"/> | Annual Salary: <input type="text"/> | Paid: <input type="checkbox"/> Hourly <input type="checkbox"/> Salary | |

Section A: Reason for Change Be sure to sign and date Section E to authorize change.

Check all coverage selections that apply to this change: **Health** **Dental** **Life** **Disability**

Change in Coverage

Terminate Coverage Dependent Change Plan Change Beneficiary Change Provider/Facility Change

Other (Explain):

Change in Personal Information Complete Section B # 1-15, with new information.

Name From: to: Address

Reason for Change Date of Event:

Adoption Birth Death Divorce Leave of Absence Loss of Coverage Marriage

Moved from Service Area Over-Aged Dependent Section 125 Terminate Employment

Other (Explain):

Section B: Personal Information

| | | | |
|---|--|---|--|
| 1. Social Security # <input type="text"/> | 2. Last Name <input type="text"/> | 3. First Name, M.I. <input type="text"/> | 4. Job Title <input type="text"/> |
| 5. Date of Birth <input type="text"/> | 6. Gender <input type="checkbox"/> M <input type="checkbox"/> F | 7. Mailing Address <input type="text"/> | |
| 8. Apt.# <input type="text"/> | | 9. City <input type="text"/> | 10. County (Ex: Duval) <input type="text"/> |
| 11. State <input type="text"/> | 12. Zip Code + 4 <input type="text"/> | 13. Area Code / Phone <input type="text"/> | |
| 14. Are You? <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated | | | |

15. This information is optional and is for data collection only. It will not be used for determining eligibility or claim payment.

Ethnicity/Race Check all that apply.

Asian or Pacific Islander Black or African American Caribbean Islander Hispanic Native American White

Primary language spoken:

Creole English French Portuguese Russian Spanish Other:

Section C: Health and Dental

16. Health

- a. BlueOptions Plan # b. BlueChoice (PPO) Plan #
 c. BlueCare (HMO offered by Health Options) Plan # d. Other Plan #
 e. Flexible Spending Account (FSA, separate application required) f. Health Reimbursement Account (HRA)

Health Coverage for: (Check one and complete # 21, 22 for eligible dependents.) *Only available where offered.

- Employee Employee & Spouse* Employee Plus One Dependent* Employee & Child(ren)* Family

17. Other Insurance Information (This section must be completed for claims processing.)

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

- Health, if BCBSF, contract # Medicare # Pharmacy Dental

18. Prior Coverage Information

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 had any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable Coverage.

Health Carrier Name Contract Number

Effective Date Prior Employee Hire Date Cancel Date Reason

State full names of all family members that were covered, including yourself. Attach separate sheet if needed, sign and date.

19. Dental

- a. BlueDental Choice (PPO) Option b. BlueDental Choice Copayment (PPO) Option
 c. BlueDental Choice Plus (PPO) Option d. BlueDental Care (Prepaid) Option
 e. BlueDental Freedom (Indemnity) Option f. Other Option

Dental Coverage for (Check one and complete # 20, 21 for eligible dependents.)

- Employee Employee & Spouse* Employee Plus One Dependent * Employee & Child(ren)* Family

* Only available where offered. If selecting Employee & Child(ren) or Family, all eligible children must be enrolled.

Note: A Dependent cannot be: (1) covered as both a dependent and an employee, including married employees of the same employer; (2) covered under more than one employee, or (3) full-time military.

20. Select Coverage for Your Eligible Dependents

Add Health For: Spouse Child 1 Child 2 Child 3 Other Dependent

Add Dental For: Spouse Child 1 Child 2 Child 3 Other Dependent

Coverage Changes Only **Remove Health For:** Spouse Child 1 Child 2 Child 3 Other Dependent
Remove Dental For: Spouse Child 1 Child 2 Child 3 Other Dependent

21. Name Your Eligible Dependents to Be Covered

Last name required if different from yours. Attach separate sheet, if needed, with additional dependents, sign and date.

| First Name, M.I., Last Name | Social Security # | Date of Birth | Gender | Check if Disabled | Check if: | | |
|---|--|---|---|--------------------------|--------------------------|--------------------------|--------------------------|
| | | | | | You Support | Lives With You | Student |
| Spouse <input type="text"/> | <input type="text" value="000-00-0000"/> | <input type="text" value="mm/dd/yyyy"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> | | | |
| Child 1 <input type="text"/> | <input type="text" value="000-00-0000"/> | <input type="text" value="mm/dd/yyyy"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Child 2 <input type="text"/> | <input type="text" value="000-00-0000"/> | <input type="text" value="mm/dd/yyyy"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Child 3 <input type="text"/> | <input type="text" value="000-00-0000"/> | <input type="text" value="mm/dd/yyyy"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Dependent Enter Relationship <input type="text"/> | <input type="text" value="000-00-0000"/> | <input type="text" value="mm/dd/yyyy"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Dental, Life and Disability are offered by Florida Combined Life.

22. BlueCare HMO Primary Care Physician

| | | |
|-----------------------|----------------------|--------------------------|
| Physician for Self | PCP ID # | Check if Current Patient |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
| Physician for Spouse | | |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
| Physician for Child 1 | | |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
| Physician for Child 2 | | |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
| Physician for Child 3 | | |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
| Other Dependent | | |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |

23. BlueDental Care Prepaid Dental Facility

| | |
|----------------------------------|--------------------------|
| Facility ID# for Self | Check if Current Patient |
| <input type="text"/> | <input type="checkbox"/> |
| Facility ID# for Spouse | |
| <input type="text"/> | <input type="checkbox"/> |
| Facility ID# for Child 1 | |
| <input type="text"/> | <input type="checkbox"/> |
| Facility ID# for Child 2 | |
| <input type="text"/> | <input type="checkbox"/> |
| Facility ID# for Child 3 | |
| <input type="text"/> | <input type="checkbox"/> |
| Facility ID# for Other Dependent | |
| <input type="text"/> | <input type="checkbox"/> |

For physicians, PCP ID #s or Dental Facility ID #s refer to the provider directory in the enrollment kit or at www.bcbsfl.com.

Section D: Life and Disability

24. Add Coverage For

- a. Basic Term Life
- b. Accidental Death & Dismemberment (AD&D)
- c. Dependent Life
- d. Hospital Indemnity
- e. Supplemental Life Amount:
- f. Supplemental AD&D
- g. Short Term Disability (STD)
- h. Long Term Disability (LTD)
- i. LTD Buy- Up

25. Add Coverage For Voluntary Products

- a. Voluntary Life For Self Amount: Spouse Amount: Child(ren) Amount:
- b. Voluntary AD&D For Self Amount: Spouse Child(ren)
- c. Voluntary Disability Voluntary Short Term Disability (VSTD) Voluntary Long Term Disability (VLTD)

If adding Spouse for Voluntary Life or AD&D, the following information regarding your Spouse is required.

| | | | |
|----------------------|--|---|---|
| Spouse's Name | Social Security # | Date of Birth | Gender |
| <input type="text"/> | <input type="text" value="000-00-0000"/> | <input type="text" value="mm/dd/yyyy"/> | <input type="checkbox"/> M <input type="checkbox"/> F |

Your Group Life Beneficiary Information Attach separate sheet, if needed, with additional beneficiaries, sign and date.

If this is a change, it revokes any existing beneficiary, other than irrevocable, for this contract. Total % must = 100%.

| Primary Beneficiary Names: | Relation to You | % of Share |
|---|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Secondary (Contingent) Beneficiary Names: | Relation to You | % of Share |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

26. Remove Coverage For

- a. Basic Term Life
- b. Accidental Death & Dismemberment (AD&D)
- c. Dependent Life
- d. Hospital Indemnity
- e. Supplemental Life Amount:
- f. Supplemental AD&D
- g. Short Term Disability (STD)
- h. Long Term Disability (LTD)
- i. LTD Buy- Up

27. Remove Coverage For Voluntary Products

- a. Voluntary Life For Self Spouse Child(ren)
- b. Voluntary AD&D For Self Spouse Child(ren)
- c. Voluntary Disability Voluntary Short Term Disability (VSTD) Voluntary Long Term Disability (VLTD)

Section E: Acceptance of Coverage

I hereby apply for the coverage/membership or apply for the change in coverage/membership or personal information that is selected on this form. My employer has selected the coverage/membership through Blue Cross and Blue Shield of Florida, Inc. ("BCBSF"), Health Options, Inc. ("HOI") and/or Florida Combined Life Insurance Company, Inc. ("FCL") (or other affiliated carrier).

I authorize my employer to deduct from my earnings my premium contribution, if any. 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, HOI and/or FCL (or any other affiliated carrier) accepts this application and assigns an effective date; and 4. If I am not actively at work on my proposed effective date of any FCL coverage, my effective date for such coverage may be deferred; it may be deferred until the date I return to active work. I understand that this application is hereby made part of the group contract.

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 AGREE that in the event of any controversy or dispute between BCBSF, HOI and/or FCL Dental, 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, HOI and/or FCL (or other affiliated carrier). 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, HOI and/or FCL to recover the excess from any person or entity that received it.

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

I acknowledge that, if I apply for BCBSF, HOI and/or FCL (or other affiliated carrier) coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period. Also, for FCL coverage, I may be required to furnish evidence of insurability. 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 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 of Applicant/Employee Date

For changes in coverage or termination of coverage

Signature of Employer Representative Date

Health Options, Florida Combined Life and Blue Cross and Blue Shield of Florida are Independent Licensees of the Blue Cross and Blue Shield Association.