



## SMALL EMPLOYER APPLICATION AMENDMENT

### I. Applicant Information

A. Group Name (from current application):  Group #:

B. Applicant hereby applies for an Amendment to the Group Policy that is currently being reviewed/issued by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this amendment by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. The effective date of the following amendment(s) to the current Policy shall be:

### II. Requested Amendment to the Current Policy

- |   |  |
|---|--|
| <input type="checkbox"/> Change: Group Name or Affiliate Name | <input type="checkbox"/> Change: Term Employees on     |
| <input type="checkbox"/> Change: Policy Effective Date        | <input type="checkbox"/> Change: Employer Contribution |
| <input type="checkbox"/> Change: Waiting Period               | <input type="checkbox"/> Change: Health Plan (Product) |
| <input type="checkbox"/> Change: Add New Employees on         | <input type="checkbox"/> Change: Other                 |

COMPLETE ONLY THOSE SECTIONS RELEVANT TO THE REQUESTED AMENDMENT TO YOUR CURRENT POLICY.

### III. Change: Group Name or Affiliate Name

New Group Name:

New Affiliate Name:

### IV. Change: Policy Effective Date

The new effective date of this Policy shall be

### V. Change: Waiting Period

New eligible employees may be covered effective after  days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements. (For Standard and Basic products the waiting period cannot exceed 90 days).

### VI. Change: Add New Employees on

Add New Eligible Employees on  1st day of billing cycle  Date of hire

### VII. Change: Term Employees on

Term Eligible Employees on:  Last day of billing cycle  Termination Date

### VIII. Change: Employer Contribution

Employer Contribution: Employee:  % Dependents  %

### IX. Change: Health Plan (Product) Single Blue Packages

### Health Plan Summary Information (complete one section for each plan selected)

Health Plan Name <input type="text"/>	Rx Option (indicate copayments): <input type="text"/>
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Calendar Year Deductible: Per Person <input type="text"/> Per Family <input type="text"/>	Coinsurance: In-Network / Participating <input type="text"/> Out-of-Network / Non-Participating <input type="text"/>
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Rates: <input type="checkbox"/> Composite <input type="checkbox"/> Table (see attached rate sheet)	Office Visit Copay: <input type="text"/>
	Family Phy. <input type="text"/>
	All Other Providers <input type="text"/>

Employee  Employee/Spouse  Employee/Child(ren)  Family  Other

Health Plan Name

Calendar Year Deductible:  
 Per Person   
 Per Family

Rates:  Composite  Table (see attached rate sheet)

Employee  Employee/Spouse  Employee/Child(ren)  Family  Other

Rx Option (*indicate copayments*):

Coinsurance:  
 In-Network / Participating   
 Out-of-Network / Non-Participating

Office Visit Copay:  
 Family Phy.   
 All Other Providers

Health Plan Name

Calendar Year Deductible:  
 Per Person   
 Per Family

Rates:  Composite  Table (see attached rate sheet)

Employee  Employee/Spouse  Employee/Child(ren)  Family  Other

Rx Option (*indicate copayments*):

Coinsurance:  
 In-Network / Participating   
 Out-of-Network / Non-Participating

Office Visit Copay:  
 Family Phy.   
 All Other Providers

Health Plan Name

Calendar Year Deductible:  
 Per Person   
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Rates:  Composite  Table (see attached rate sheet)

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Coinsurance:  
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Office Visit Copay:  
 Family Phy.   
 All Other Providers

Health Plan Name

Calendar Year Deductible:  
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Rx Option (*indicate copayments*):

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 Out-of-Network / Non-Participating

Office Visit Copay:  
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 All Other Providers

Health Plan Name  Rx Option (indicate copayments):

Calendar Year Deductible:  Coinsurance:

Per Person  In-Network / Participating

Per Family  Out-of-Network / Non-Participating

Rates:  Composite  Table (see attached rate sheet) Office Visit Copay:

Family Phy.

All Other Providers

Employee  Employee/Spouse  Employee/Child(ren)  Family  Other

Health Plan Name  Rx Option (indicate copayments):

Calendar Year Deductible:  Coinsurance:

Per Person  In-Network / Participating

Per Family  Out-of-Network / Non-Participating

Rates:  Composite  Table (see attached rate sheet) Office Visit Copay:

Family Phy.

All Other Providers

Employee  Employee/Spouse  Employee/Child(ren)  Family  Other

**Health Savings Account (HSA) Banking Arrangement** (optional with HSA compatible health plans)

Are you choosing BCBSF's integrated HSA banking arrangement  Yes  No  
 (if left blank, the response is assumed to be no.)

By choosing the HSA Banking Arrangement, If applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, **with BCBSF's preferred bank**, for the purposes of initial enrollment in and administration of, HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.

**X. Change: Other**

Upon acceptance for coverage this amendment will become a part of the Group Policy issued, along with the Small Employer Application. The applicant certifies the information contained in this amendment is true and complete and acknowledges that if a misrepresentation was made regarding eligibility, this coverage may be cancelled or rescinded. The applicant understands 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.

Issuance of the Policy by BCBSF and/or HOI will be deemed acceptance of this amendment.

Date Signature of Applicant Print/Type Name & Title

Date Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Signature of Agent

Agent License Identification Number