BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Health Change Application

Please type or write clearly in black or blue ink.

Section A: Current Information

Group Name:	Group #:	Division #:	Package #:
Employee Name: (Last, First Name, M.I.)	Social Security #:	Effective Date of Coverage:	Date of Event:

Section B: Coverage Change Information

Reason for Change:

- ☐ Adoption
- ☐ Death
- ☐ Leave of Absence/Layoff
- ☐ Moved from Service Area
- ☐ Open Enrollment
- ☐ Section 125
- ☐ Marriage
- ☐ Birth
- ☐ Over-Aged Dependent
- ☐ Terminate Employment
- ☐ Return of Alternate Insurance
- ☐ Loss of Coverage
- ☐ Divorce
- ☐ Location _____
- ☐ Employee # _____
- ☐ Other _____

Change Request Type:

- ☐ New Name:
- ☐ New Physician Name/ID:
- ☐ New Address:
- ☐ New Phone #:

Plan Coverage Type Requested: ☐ Add Health ☐ Delete Health ☐ Change Plan: *Indicate Plan #*

Coverage Level Requested: ☐ Employee ☐ *Employee & Spouse ☐ *Employee & One Dependent ☐ *Employee & Children ☐ Family
** When available*

☐ Dependent Change *Complete Section C*

☐ Other Change:

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

Last Name: *(if different than employee)* First Name, M.I.	Social Security Number:	Birth Date:	Relation to You: Spouse (S)	Child (C)	Other (O)*	Sex (M or F)	Check if Disabled	Physician Name/ID *HMO only*	Existing Patient (Y/N)	Dependent: You Support	Lives With You	Is a Student	Ethnicity *optional Circle all that apply.*
							☐			☐	☐	☐	A B C H N W
							☐			☐	☐	☐	A B C H N W
							☐			☐	☐	☐	A B C H N W
							☐			☐	☐	☐	A B C H N W

A) Asian/Pacific Islander
B) Black/African American
C) Caribbean Islander
H) Hispanic
N) Native American
W) White

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 BCBSF plans) that will be in effect after this coverage begins? ☐ Yes ☐ No

BCBSF 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 Heath 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 Blue Shield of Florida, Inc. ("BCBSF") and/or Health Options, Inc. ("HOI") contract that is selected on this form. I understand and agree that the changes will not be effective until this application is accepted by BCBSF and/or HOI.

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 BCBSF and/or HOI 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 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 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 BCBSF and/or HOI, 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 and/or HOI. 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 and/or HOI to recover the excess from any person or entity that received it.

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

I acknowledge that, if I apply for BCBSF and/or HOI 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.

If applying for Miami-Dade Blue, I understand there is no participating provider network outside of Miami-Dade County. I will be responsible for all charges that exceed BCBSF's payment amount for services received from non-participating providers.