

## **Health Change Application**

Please type or write clearly in black or blue ink.

Section A	Current Information	on																
Group Name:				Group #:								#:	#: Package #:					
Employee	e Name: (Last, Fi	Social Sec	Social Security #: Effective Date of Coverage								e: Date of Event:							
Section B	: Coverage Chan	ge Information																
Reason for Change:	☐ Adoption ☐ Open Enrollm ☐ Over-Aged D ☐ Divorce	ependent 🗌 Term	ion 125		<ul><li>☐ Marriage</li><li>☐ Return of Alternate Insurance</li><li>☐ Employee #</li></ul>					<ul><li>☐ Moved from Service Area</li><li>☐ Birth</li><li>☐ Loss of Coverage</li><li>☐ Other</li></ul>								
Change	□ New Name:									☐ New Physician Name/ID:								
Request Type:	☐ New Address									☐ New Phone #:								
Plan Cove	erage Type Reques	sted:   Add Health	☐ Delete Health		Char	nge l	Plai	n: Indicate Plan #										
Coverage * When av	Level Requested:	☐ Employee ☐ *E	mployee & Spous	se 🗆	∃*En	nplo	yee	e & One Dependent □*E	mp	loy	/ee	& Ch	ildr	ren		Fai	nily	
☐ Depend		Other Change:																
Section C	: Dependent Info	ormation Attach sep	arate sheet, if add	ditiona	al sp	ace	is n	needed, with dependent in	forn	nat		_						
Last Name			-	Rela	ation You		p	it (Y/N)				Ethnicity optional Circle all that apply.  A) Asian/Pacific Islander						
Last Name: (if different than employee) First Name, M.I.		Social Security Number:	Birth Date:	Spouse (S)	Other (O)*	Sex (M or F)	Check if Disabled	Existing Patient (Y/N)  Existing Patient (Y/N)	Tod With Year	LIVES VVIII TOU	a Student	B) Black/African American C) Caribbean Islander H) Hispanic						
												A E	3	С	Н	N	W	
												A E	3	С	Н	N	W	
												A E	3	С	Н	N	W	
												A E	3	С	Н	N	W	
	•	ation to You" above the						ild(ren) or lives outside of here:	Flor	ida	a. —							
Section F	). Other Health In	surance Information	on This section m	nust b	e coi	mple	etec	I for claims processing an	d P	rio	or C	Cover		ıe İn	for	mat	ion	
In addition		ou or your dependents No		nsurar		•		e (including BCBSF plans) the	nat	will	be							
Complete t coverage;	he following only if the	nis is the first time you	or your dependents	s: (1) a	are ei	nrolli rage	ng f	or health insurance with this places OR you can attach a C	em	oloy	yer;	(2) cu	urre dita	ently l	hav Cov	e he	alth ge.	
Prior Hea	th Carrier Name:		Contract #:							Effective Date:								
Prior Employee Hire Date: Cancel Date: List names of all family members that we									ere	CO	ver	ed, ii	ncl	udin	g y	our/	self:	
Employee	e Signature:			l				Date:										
Employer Signature:										Date:								

## **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.