

Section A: Current Information

Group Name:			Group #:		Division #:	Package #:
Effective Date of Coverage:	Date of Hire:	Location #:	Employee #:	Job Title:		
Work Status: ☐ Actively at Work ☐ Cobra ☐ Retired		Retirement Date:		Paid: ☐ Hourly ☐ Salary ☐ Open Enrollment		

Section B: Employee Information

Social Security #:	Last Name:	First Name:	M.I.:	Birth Date:	Sex: ☐ M ☐ F
Street Address:		Apt. #:	City:	State:	Zip:
County:	Phone:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated			
Physician Name / ID # <i>HMO only</i> :	Existing Patient: ☐ Yes ☐ No	Language of Preference: <i>optional - for data collection purposes only</i> ☐ English ☐ Spanish ☐ Other ☐ Prefer not to answer			

Ethnicity *optional*
Check all that apply: ☐ Asian/Pacific Islander ☐ Black/African American ☐ Caribbean Islander ☐ Hispanic ☐ Native American ☐ White

Section C: Health Coverage Level and Plan Information

Employee Health Coverage: ☐ Employee ☐ *Employee & Spouse ☐ *Employee & One Dependent ☐ *Employee & Child(ren) ☐ Family <i>*When available</i>		
☐ BlueOptions Plan # _____	☐ BlueChoice (PPO) Plan # _____	☐ BlueCare (HMO) Plan # _____
☐ BlueSelect Plan # _____	☐ Other Plan # _____	

☐ I am Refusing all Health Coverage at this time. I understand that if I decide to apply later coverage may not be available until the next open or special enrollment period. Signature: _____ Date: _____

Section D: Vision Coverage Level and Plan Information

Employee Vision Coverage: ☐ Employee ☐ *Employee & Spouse ☐ *Employee & One Dependent ☐ *Employee & Child(ren) ☐ Family

Vision Plan Choice:

☐ I am Refusing all Vision Coverage at this time. I understand that if I decide to apply later coverage may not be available until the next open or special enrollment period. Signature: _____ Date: _____

Section E: 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					Plan Type		Sex (M or F)	Check if Disabled	Physician Name/ID <i>HMO only</i>	Existing Patient (Y/N)	Dependent			Ethnicity <i>optional</i> <i>Circle all that apply.</i>
			Spouse (S)	Child (C)	Domestic Partner (DP)	Domestic Part. Child (DPC)	Other (O)*	Health	Vision					You Support	Lives With You	Is a Student	
								☐	☐					☐	☐	☐	A B C H N W
								☐	☐					☐	☐	☐	A B C H N W
								☐	☐					☐	☐	☐	A B C H N W
								☐	☐					☐	☐	☐	A B C H N W

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 F: 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 Florida Blue plans) that will be in effect after this coverage begins? ☐ Yes ☐ No

Florida Blue 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 Health Carrier Name: _____ Contract #: _____ Effective Date: _____

Prior Employee Hire Date: _____ Cancel Date: _____ List names of all family members that were covered, including yourself: _____

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: _____

Section G: Acceptance of Coverage

Plan Coverage Terms

I hereby apply for the coverage/membership that is selected on this form. My employer has selected health and/or vision coverage through Florida Blue and/or HMO coverage through Florida Blue HMO.

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 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.

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 affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.