



Section A: Current Information

Group Name:			Group #:		Division #:	Package #:
Effective Date of Coverage:	Date of Hire:	Location #:	Employee #:	Job Title:		
Work Status: <input type="checkbox"/> Actively at Work <input type="checkbox"/> Cobra <input type="checkbox"/> Retired		Retirement Date:		Paid: <input type="checkbox"/> Hourly <input type="checkbox"/> Salary		<input type="checkbox"/> Open Enrollment

Section B: Employee Information

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

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

Section C: Coverage Level and Plan Information

Employee Health Coverage: <input type="checkbox"/> Employee <input type="checkbox"/> *Employee & Spouse <input type="checkbox"/> *Employee & One Dependent <input type="checkbox"/> *Employee & Child(ren) <input type="checkbox"/> Family <i>* When available</i>		
<input type="checkbox"/> BlueOptions Plan # _____	<input type="checkbox"/> BlueChoice (PPO) Plan # _____	<input type="checkbox"/> BlueCare (HMO) Plan # _____
<input type="checkbox"/> BlueSelect Plan # _____	<input type="checkbox"/> Miami-Dade Blue Plan # _____	<input type="checkbox"/> MyBasic Plan # _____
<input type="checkbox"/> Other Plan # _____		
<input type="checkbox"/> 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: Dependent Information *Attach separate sheet, if additional space is needed, with dependent information, sign & date.*

Last Name: <i>(if different than employee)</i> First Name, M.I.	Social Security Number:	Birth Date:	Relation to You			Sex (M or F)	Check if Disabled	Physician Name/ID <i>HMO only</i>	Existing Patient (Y/N)	Dependent				Ethnicity <i>optional</i> <i>Check all that apply.</i>					
			Spouse (S)	Child (C)	Other (O)*					You Support	Lives With You	Is a Student	A) Asian/Pacific Islander	B) Black/African American	C) Caribbean Islander	H) Hispanic	N) Native American	W) White	
							<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A	B	C	H	N	W	
							<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A	B	C	H	N	W	
							<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A	B	C	H	N	W	
							<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 E: 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 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 F: Acceptance of Coverage

Plan Coverage Terms

I hereby apply for the coverage/membership that is selected on this form. My employer has selected the coverage/membership through Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") and/or Health Options, Inc. ("HOI").

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 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.