Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Employee Enrollment Application

Please type or write clearly in black or blue ink.

Rvsd 9/20/19

Section A: Current Information

Group Name: **Bay County Board Employees** | Group #: **45444** | 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 # | Existing Patient: ☐ Yes ☐ No | Language of Preference: *optional - for data collection purposes only* ☐ 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: **Blue Options Plans**
**When available*

☐ Plan # 03160 Hi Deductible @ $1400 ☐ Employee Only

☐ Plan # 03161 Hi Deductible @ $2800 ☐ *Employee & Spouse ☐ *Employee &Child(ren) ☐ Family

☐ 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: *(if different than employee)* First Name, M.I.	Social Security Number:	Birth Date:	Relation to You: Spouse (S)	Child (C)	Domestic Partner (DP)	Domestic Part. Child (DPC)	Other (O)*	Plan Type: Health	Vision	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) Asian/Pacific Islander B) Black/African American C) Caribbean Islander H) Hispanic N) Native American W) White
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List the name of each dependent listed above that is married or has dependent child(ren) or lives outside of Florida.

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

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:

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: