Florida Blue
In the pursuit of health®

Florida's Blue Cross and Blue Shield Plan

Health Change Application

Please type or write clearly in black or blue ink.

Rvsd 9/20/19

Section A: Current Information

Group Name: Bay County Employees	Group #: 45444	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
- ¨ Open Enrollment
- ¨ Over-Aged Dependent
- ¨ Divorce
- ¨ Death
- ¨ Section 125
- ¨ Terminate Employment
- ¨ Location_____
- ¨ Leave of Absence/Layoff
- ¨ Marriage
- ¨ Return of Alternate Insurance
- ¨ Employee #_____
- ¨ Moved from Service Area
- ¨ Birth
- ¨ Loss of Coverage
- ¨ Plan Type:_____ (ex. PPO, HMO, RX)

Change Request Type:

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

Plan Coverage Type Requested: ¨ Add Health ¨ Delete Health ¨ Change Plan: Indicate Plan #

Coverage Level Requested: ☐ Employee ☐ *Employee & Spouse ☐ *Employee & Children ☐ Family

* When available

¨ Dependent Change Complete Section C ¨ Other Change:

Applicable to Group Administrator: The Affordable Care Act prohibits rescissions; cancellations cannot be submitted for the period in which a premium is collected. By submitting cancellation(s) you represent that you have not collected a premium from the employees/ dependents for coverage after the requested termination date.

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

Last Name: (if different than employee) First Name, M.I.	Social Security Number	Birth Date	Relation to You			Sex (M or F)	Check if Disabled	Physician Name/ID HMO only	Existing Patient (Y/N)	Dependent			Ethnicity optional Check all that apply.
			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
													¨ 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 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. 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.

Prior Health 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: