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.

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 # *HMO only*: | 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: ☐ Employee ☐ *Employee & Spouse ☐ *Employee & One Dependent ☐ *Employee & Child(ren) ☐ Family
**When available*

☐ 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: Spouse (S)	Child (C)	Domestic Partner (DP)	Domestic Part. Child (DPC)	Other (O)*	Plan Type: Health	Plan Type: Vision	Sex (M or F)	Check if Disabled	Physician Name/ID *HMO only*	Existing Patient (Y/N)	Dependent: You Support	Dependent: Lives With You	Dependent: Is a Student	Ethnicity *optional Circle all that apply.*
								☐	☐		☐			☐	☐	☐	A B C H N W
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A) Asian/Pacific Islander
B) Black/African American
C) Caribbean Islander
H) Hispanic
N) Native American
W) White

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.

Florida Blue
In the pursuit of health®

Nondiscrimination and Accessibility Notice (ACA §1557)

Florida Blue and Florida Blue HMO comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Florida Blue and Florida Blue HMO does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Florida Blue and Florida Blue HMO provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact 1-800-352-2583.

If you believe that Florida Blue and Florida Blue HMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Senior Manager of Business Ethics
4800 Deerwood Campus Parkway, DC1-7
Jacksonville, FL 32246
Phone 800-477-3736 X56300 (TTY: 800-955-8770)
Fax 904-357-8203
Email compass@floridablue.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Senior Manager of Business Ethics is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human
Services, 200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
800–868–1019, 800–537–7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

Florida Blue
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Have a disability? Speak a language other than English? Call to get help for free.
1-800-352-2583 (TTY: 1-800-955-8770)

¿Habla español? ¿Tiene alguna discapacidad? Llame para obtener ayuda de forma gratuita al 1-800-352-2583 (TTY: 1-877-955-8773)

Èske w pale kreyòl ayisyen? Èske w andikape? Rele nou pou w jwenn èd graris.
1-800-352-2583 (pou moun ki tande di: 1-800-955-8770)

Quý vị nói tiếng Việt? Quý vị bị khuyết tật? Hãy gọi trợ giúp miễn phí.
1-800-352-2583 (TTY: 1-800-955-8770)

Você fala potuguês? Tem alguma deficiência? Telefone para obter assistência.
1-800-352-2583 (TTY: 1-800-955-8770)

您会讲中文吗？是否为伤残人士？如需帮助，请拨打我们的免费电话：
1-800-352-2583（TTY：1-800-955-8770）

Vous parlez français ? Vous avez une incapacité ? Appelez pour recevoir une assistance gratuite. 1-800-352-2583 (TTY: 1-800-955-8770)

Nagsasalita ng Tagalog o Filipino? May kapansanan? Tumawag para sa libreng tulong.
1-800-352-2583 (TTY: 1-800-955-8770)

Вы говорите по-русски? Вы являетесь инвалидом? Свяжитесь с нами для получения бесплатной помощи по телефону 1-800-352-2583 (телетайп: 1-800-955-8770)

هل تتحدث (العربية)؟ هل لديك إعاقة؟ اتصل للحصول على مساعدة مجانية. 1-800-352-2583 (التواصل للذين يعانون من مشاكل في السمع: 1-800-955-8770)

Parli italiano? Hai una disabilità? Chiama per un'assistenza gratuita.
1-800-352-2583 (TTY: 1-800-955-8770)

Sprechen Sie deutsch? Haben Sie eine Behinderung? Rufen Sie an, um kostenlos Hilfe zu erhalten. 1-800-352-2583 (TTY: 1-800-955-8770)

한국어 통역이 필요하세요? 장애가 있나요? 전화하시면 무료로 도와드립니다.
1-800-352-2583 (TTY: 1-800-955-8770)

Mówi po polsku? Czy ma niepełnosprawność? Zadzwoń po bezpłatną pomoc.
1-800-352-2583 (TTY: 1-800-955-8770)

ગુજરાતી બોલો છો? અક્ષમતા ધરાવો છો? મફત સહાયતા મેળવવા ફોન કરો. s
1-800-352-2583 (TTY: 1-800-955-8770)

พูดภาษาไทยได้? เป็นผู้พิการใช่หรือไม่? โทรศัพท์ขอรับคำปรึกษาได้ฟรีที่ 1-800-352-2583

(หมายเลขโทรศัพท์สำหรับผู้พิการทางการได้ยิน: 1-800-955-8770)

日本語をご希望ですか？障害をお持ちですか？無料の電話サービスをご利用ください。1-800-352-2583 (TTY: 1-800-955-8770)

به زبان فارسی صحبت می کنید؟ دارای معلولیت هستید؟ برای دریافت کمک رایگان تماس بگیرید. 1-800-352-2583 (تلفن ناشنوایان: 1-800-955-8770)

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