BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

Employee Enrollment/Change Form

Check Desired Action

☐ **New Member**

Date of Hire:_____

Coverage Eff Date:_____

Changes

☐ **Add Dependent**

☐ **Cancel Subscriber**

☐ **Cancel Dependent**

☐ **Change Employee Information**

Indicate Election Change

☐ Medical

☐ Dental

Reason for Change:_____

Effective Date:_____

Employee Information

Social Security #: _____ **Sex:** ☐ M ☐ F **Birth date:**_____

Last:_____ **First:**_____

Street:_____

City:_____ **State:**_____ **Zip:**_____

Phone:_____ **Email Address:**_____

Employer use only:

Effective Date of Change:_____

Location Number:_____

Eligible for COBRA: _____

Pay Frequency:_____

Coverage Election:

MEDICAL	TYPE	DENTAL
☐ Employee	☐ PPO	☐ Employee
☐ Employee + Spouse	☐ HSA	☐ Family
☐ Employee + Child(ren)		☐ Waive
☐ Family		
☐ Waive		

WELLNESS: ☐ Yes ☐ No

DEPENDENT INFORMATION - *Check relationship and indicate dependent name and requested information*

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

☐ (S)pouse ☐ (D)ependent Social Security #:_____ Sex ☐ M ☐ F

☐ Other:_____ Birth date(mm/dd/yy): ___/___/___

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

☐ (S)pouse ☐ (D)ependent Social Security #:_____ Sex ☐ M ☐ F

☐ Other:_____ Birth date(mm/dd/yy): ___/___/___

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

☐ (S)pouse ☐ (D)ependent Social Security #:_____Sex ☐ M ☐ F

☐ Other:_____ Birth date(mm/dd/yy): ___/___/___

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

☐ (S)pouse ☐ (D)ependent Social Security #:_____Sex ☐ M ☐ F

☐ Other:_____ Birth date(mm/dd/yy): ___/___/___

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

☐ (S)pouse ☐ (D)ependent Social Security #:_____Sex ☐ M ☐ F

☐ Other:_____ Birth date(mm/dd/yy): ___/___/___

OTHER HEALTH COVERAGE/COORDINATION OF BENEFITS

Do you or any family member currently have other health and/or dental coverage? ☐ Yes, single ☐ Yes, family ☐ No

If yes to the above question, complete the following: Insured Person's Name:_____

Employer Name:_____ Carrier Name:_____ Plan Number:_____

WAIVING COVERAGE

If you decline benefits for yourself or your dependents, you may in the future be able to enroll yourself or your dependents in this benefit plan. You may have an opportunity to enroll during your annual enrollment period or if your family status changes. If you decline benefits because of other group health or insurance coverage, and state so in writing, you may have the opportunity to enroll under HIPAA Special Enrollment because of loss of that coverage. Even if you do not have other health or insurance coverage, you may have a future opportunity to enroll due to eligibility under a Medicaid/CHIP Subsidy program. By checking the box below, you are attesting that you are declining enrollment in this plan because you are enrolled in other group health coverage:

☐ I attest that I am declining group health coverage because I am currently enrolled in other group health or insurance coverage.

CERTIFICATION: I freely and voluntarily waive all coverage noted above.

_____ _____

EMPLOYEE SIGNATURE **DATE**

I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage. I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan.

_____ _____

EMPLOYEE SIGNATURE **DATE**