



Employee Enrollment Application

Please type or write clearly in black or blue ink.

Section A: Current Informat	ion																							
Group Name:					Group #:							Division #: Package #:												
Effective Date of Coverage:	Date of	Hire:	Location	ר#:		E	Emp	loye	e#		Job Title:													
Work Status:	at Work	Cob	ra 🗌 Reti	red	Ret	iren	nent	Dat	te:					Paid:	Ηοι	urly		Sa	lary		Оре	n Er	nrolli	ment
Section B: Employee Inform	nation																			-				
Social Security #: Last Name:							First Name:						1.I.: Birth Date: Sex: □ M □ F											
Street Address:								A	pt. #	: (City	/:					1		Sta	te:	Zip:			
County:		Phone:							N			Stat le [arried [] Div	vorc	ed		Wid	lowe	ed [_ L _ S	ega epa	lly irated
Physician Name / ID # HMO o	only:		ting Patien /es 🗌 No		-	-								data coll	ectio	n pi	urpo	ses		-	refer	not	to ar	nswer
Check all that apply.			r 🗌 Blac			n A	mer	can		Са	aribl	bear	n Isla	nder 🗌] His	pan	ic		Nativ	ve A	mer	icar	ו 🗆	Whi
Section C: Health Coverage	·																							
Employee Health Coverage: *When available	Empl	oyee 🗌] *Employe	e &	Spc	ouse]*E	mple	bye	e &	One	e De	pendent		*Err	plo	yee	* & C	hild((ren)		Far	nily
BlueOptions Plan #		BlueChoice (PPO) Plan #								🗌 Blue	3lueCare (HMO) Plan #													
BlueSelect Plan #	🗆 Truli F	Truli For Health (HMO) Plan # Other									er Pla	Plan #												
I am Refusing all Health next open or special enr			s time. I ur Signatu		rstar	nd t	hat	if I c	deci	de t	to a	appl	y late	er cover	age	ma	y n	ot k	be a Da		able	unt	il th	е
Section D: Vision Coverag	je Level	and Pla	in Informa	atior	۱																			
Employee Vision Coverage:	Empl	oyee 🗌]*Employe	e &	Spc	ouse] *E	mpl	bye	e &	One	e De	pendent		*Err	plo	yee	& C	hild((ren)		Far	nily
Vision Plan Choice:																								
□ I am Refusing all Vision next open or special er					ersta	and	that	if I	dec	ide	e to	арр	oly la	ter cove	erage	e m	ay ı	not	be a Da		ilable	e ur	ntil tł	าย
Section E: Dependent Info	ormation	Attach s	eparate sh	heet	, if a	addit	tiona	al sp	ace	is I	nee	eded	l, with	n depen	dent	info	orma	atio	n, si	gn {	& dai	te.		
			irth Date:	Relation				i iun								De	penc	dent		Ethnicity optional Circle all that apply.				
Last Name: <i>(if different than employee)</i> First Name, M.I.	Socia Securi Numbe	ity B		Spouse (S)	Child (C)	Domestic Partner (DP)	Domestic Part. Child (DPC)	Other (O)*	Health	Vision	Sex (M or F)	Check if Disabled	Na	ysician ame/ID 10 only	Existing Patient (Y/N)	You Support	Lives With You	Is a Student	B) E C) (H) H N) N W)	A) Asian/Pacific Isla B) Black/African Am C) Caribbean Island H) Hispanic N) Native American W) White			Ame ande an	nerican der
																			A	В	С	Η	Ν	W
																			А	В	С	Η	Ν	W
																			Α	В	С	Η	Ν	W
																			Α	В	С	Н	Ν	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 F: Other Health Insurance Information	on This section m	nust be completed for clai	ms processing and Prior Coverage Information
In addition to this policy, do you or your dependent effect after this coverage begins? Yes No Florida Blue and/or Truli for Health Contract #			
		Medicare #	
			h insurance with this employer; (2) currently have health R 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:
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 and/or Truli for Health.

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, Florida Blue

HMO and/or Truli for Health 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 and/or Truli for Health 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, Florida Blue HMO and/or Truli for Health, 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, Florida Blue HMO and/or Truli for Health. 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 and/or Truli for Health to recover the excess from any person or entity that received it.

I acknowledge that Florida Blue, Florida Blue HMO and/or Truli for Health 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, Florida Blue HMO and/or Truli for Health coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period.

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.

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:

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue. HMO coverage is offered by Health Options, Inc., DBA Florida Blue HMO and/or BeHealthy Florida, Inc., DBA Truli for Health. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.