Florida Blue | truli for health A Florida Blue Affiliate

Employee Change Application

Please type or write clearly in black or blue ink.

Section A: Current Information

Group Name:	Group #:	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
- ☐ Death
- ☐ Leave of Absence/Layoff
- ☐ Moved from Service Area
- ☐ Open Enrollment
- ☐ Section 125
- ☐ Marriage
- ☐ Birth
- ☐ Over-Aged Dependent
- ☐ Terminate Employment
- ☐ Return of Alternate Insurance
- ☐ Loss of Coverage
- ☐ Divorce
- ☐ Location_____
- ☐ Employee #_____
- ☐ 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 ☐ Add Vision ☐ Delete Vision ☐ Change Plan: *Indicate Plan #*

Coverage Level Requested: ☐ Employee ☐*Employee & Spouse ☐*Employee & One Dependent ☐*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			Plan Type		Sex (M or F)	Check if Disabled	Physician Name/ID *HMO only*	Existing Patient (Y/N)	Dependent			Ethnicity *optional* *Check all that apply.* A - Asian/Pacific Islander B - Black/African American C - Caribbean Islander H - Hispanic N - Native American W - White
			Spouse (S)	Child (C)	Other (O)*	Health	Vision					You Support	Lives With You	Is a Student	
						☐	☐		☐			☐	☐	☐	☐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 Florida Blue and/or Truli for Health plans) that will be in effect after this coverage begins? ☐ Yes ☐ No
Florida Blue and/or Truli for Health 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:

Section E: Change Authorization

Plan Coverage Terms

I hereby authorize the changes to my Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue, Health Options, Inc., DBA Florida Blue HMO and/or BeHealthy Florida, Inc. DBA Truli for Health contract that is selected on this form. I understand and agree that the changes will not be effective until this application is accepted by Florida Blue, Florida Blue HMO and/or Truli for Health.

I authorize my employer to deduct from my earnings my premium contribution, if any, including any additional amounts required as a result of the changes indicated on this Health Change Application. 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, 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 a copy of the Summary of Benefits and Coverage (SBC) can be obtained by contacting my Group Administrator.

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: