

## **Health & Financial Change Application**

Please type or write clearly in black or blue ink.

	A: Current Informati	on																
Group	Name:			(	Gro	oup	#:			[	Divi	sion	ı #:	Pa	acka	ge #:		
Employee Name: (Last, First Name, M.I.) Social Security						#: Effective Date of Coverage					: Date of Event:							
Section	B: Coverage Chan	ge Information	·															
Reason Change	☐ Over-Aged D	eath ection 125 erminate Employment ecation			<ul><li>☐ Marriage</li><li>☐ Return of Alternate Insurance</li></ul>						<ul><li>☐ Moved from Service Area</li><li>☐ Birth</li><li>☐ Loss of Coverage</li><li>☐ Other</li></ul>							
Change	□ New Name:											☐ New Physician Name/ID:						
Reques Type:	□ New Address:											☐ New Phone #:						
Plan Co	overage Type Reques	sted:   Add Health	☐ Delete He	alth	C	han	ge I	Plar	n: Indicate Plan #									
Covera * When	ge Level Requested: available	□ Employee □*E	Employee & S	oouse	;	*Em	plo	yee	& One Dependent	*En	nplc	yee	& Ch	nildre	n [	∃Fa	mily	
□ Depe Com	endent Change	SA Change Complete Section C	☐ Other Ch	ange:														
Section	C: Flexible Spendin	g Account (FSA) C	hanges															
☐ Add Health Care FSA						☐ Add Dependent Care FSA												
I wish to Terminate and/or Stop Pay my FSA Health Care Program with a Final Payroll Deduction Date of:						☐ I wish to Terminate and/or Stop Pay my FSA Dependent Care Program with a Final Payroll Deduction Date of:												
☐ I wish to Change the Annualized Amount of my Health Care FSA to: \$						☐ I wish to Change the Annualized Amount of my Dependent Care FSA to: \$												
Amoun		Effective Date:			Payroll Deduction Amount \$:					Effective Date:								
I wish t	o change my Payroll	Frequency to: U	Veekly ☐ Bi-\	weekly		Mc	nth	ly	□ Bi-monthly □ Other	•								
	D: Dependent Info	ormation Attach sep	parate sheet, i				се	is n	eeded, with dependent	info	rma	ation	, sign	1 & 0	late.			
(A) Add (D) Delete (C) Change	Last Name: If different than employee First Name, M.I.	Social Security Number:	Birth Date	to	Child (C) blind	ou *	Sex (M or F)	Check if Disabled			Lives With You Is a Student		Ethnicity optional Circle all that apply.  A) Asian/Pacific Islander B) Black/African American C) Caribbean Islander H) Hispanic N) Native American W) White					
													A I	ВС	ЭН	N	W	
													A I	ВС	СН	N	W	
													A I	ВС	Э	Ν	W	
* If you	indicated "O" in "Rela	ation to You" above	for any depen	idents r	olea	ase	exn	□ lain	here:				A I	ВС	СН	N	W	
you	Thereaced 5 in real			idonto, p	0100		<u>олр</u>	- Iuii										
									for claims processing a								ion	
coverag	e begins? Yes N	No BCBSF Contrac	t #	dente: /1	M	edic	are	#_	(including BCBSF plans) Phari	mac	y /N	/ledi	care	D#.	th cha	vo bo		
	e; and/or (3) have any l eath Carrier Name:	health coverage in the	past 12 month	s that th		over Co			or health insurance with th laces OR you can attach a				of Cre		ole Co	vera	ge.	
	mployee Hire Date:		Cancel Date:	Lis	t na	ame	es o	of al	Il family members that	wer	e c	ove	ed, i	nclu	ding	your	self:	
	F: Change Authoriza read, understand, ar		•	ation ar	nd/c	or P	artio	cipa	ation in the FSA Progra	m T	erm	ns o	n the	bac	k of	this 1	orm	
I under	rstand that any pera	son who knowing	ly and with in	ntent to	inj na	jure info	, de	efra	aud, or deceive any in on is guilty of a felony	sur of	er f the	iles thi	a sta rd de	aten	nent e.	of cl	aim	
Employee Signature:											Date:							
Employ	ver Signature:												Date	e:				

## **Plan Coverage Terms**

I hereby authorize the changes to my Blue Cross Blue Shield of Florida, Inc. ("BCBSF") and/or Health Options, Inc. ("HOI") contract that is selected on this form. I understand and agree that the changes will not be effective until this application is accepted by BCBSF and/or HOI.

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 & Financial 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 BCBSF and/or HOI 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 BCBSF 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 I cannot have both, an FSA and an HSA through BCBSF as it conflicts with IRS code.

## **FSA Terms**

If my employer offers an FSA and I elect, through the changes on the reverse side of this form, to participate through payroll deduction. I understand and agree to the following:

- 1. My FSA election will remain in effect for the duration of the plan year and to participate in succeeding years, I must complete a new election form;
- 2. I cannot suspend, increase or decrease my payroll deductions during the plan year unless, I experience a valid change in status, as defined in the Plan Documents and in accordance with Federal Tax Law;
- 3. I cannot submit claims incurred prior to the date that I joined the FSA Program or after the plan year ends (unless, the employer's Plan Document allows for carry over as prescribed in Federal Internal Revenue Service rules);
- 4. My employer is not responsible for any tax liabilities that I may incur as a result of my participation in the FSA Program; and
- 5. I authorize payroll deductions for the total amount(s) indicated into my Flexible Spending Account(s).

## **General Terms**

I AGREE that in the event of any controversy or dispute between BCBSF and/or HOI, 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 BCBSF and/or HOI. 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 BCBSF and/or HOI to recover the excess from any person or entity that received it.

I acknowledge that BCBSF and/or HOI coverage/membership is contingent upon the complete, accurate disclosure of the information requested on this form.

I acknowledge that, if I apply for BCBSF and/or HOI 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.