



Group Health Employee Application/Change Form Please forward to: FHCP Enrollment Dept.

An Independent Licensee of the Blue Cross and Blue Shield Association
 2450 Mason Avenue, Daytona Beach, FL 32114
PLEASE PRINT CLEARLY

EMPLOYER USE ONLY: Group No: _____ Employer: _____ Phone: _____
 Effective Date: _____ Hire Date: _____ Dept. Location: _____

<p>ENROLLMENT:</p> <input type="checkbox"/> New Enrollment (28) <input type="checkbox"/> Open Enrollment Plan Change (22) <input type="checkbox"/> Waive Coverage (26)	<p>CHANGE: * REASON FOR CHANGE: Please check appropriate box or enter code number from box on back: _____</p> <table border="0"> <tr> <td><input type="checkbox"/> Add (021)</td> <td><input type="checkbox"/> Change (001)</td> <td><input type="checkbox"/> Divorce (C)</td> <td><input type="checkbox"/> Retired (R)</td> <td><input type="checkbox"/> Term of Employment (1)</td> </tr> <tr> <td><input type="checkbox"/> Terminate (024)</td> <td><input type="checkbox"/> Reinstate (025)</td> <td><input type="checkbox"/> Reduction in Hours (E)</td> <td><input type="checkbox"/> Declined Coverage (W)</td> <td><input type="checkbox"/> Other Coverage (6)</td> </tr> <tr> <td colspan="2">Eff. Date: ____/____/____</td> <td><input type="checkbox"/> Plan Code Change (J)</td> <td><input type="checkbox"/> Other Term Reason (0)</td> <td><input type="checkbox"/> Death (9)</td> </tr> </table>	<input type="checkbox"/> Add (021)	<input type="checkbox"/> Change (001)	<input type="checkbox"/> Divorce (C)	<input type="checkbox"/> Retired (R)	<input type="checkbox"/> Term of Employment (1)	<input type="checkbox"/> Terminate (024)	<input type="checkbox"/> Reinstate (025)	<input type="checkbox"/> Reduction in Hours (E)	<input type="checkbox"/> Declined Coverage (W)	<input type="checkbox"/> Other Coverage (6)	Eff. Date: ____/____/____		<input type="checkbox"/> Plan Code Change (J)	<input type="checkbox"/> Other Term Reason (0)	<input type="checkbox"/> Death (9)
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I. EMPLOYEE INFORMATION: (PLEASE PRINT) To be completed by all eligible employees, those waiving coverage, and former employees covered by COBRA.

Last Name: _____ First: _____ MI: _____ Prior Name (if applicable): _____ Phone No.: _____ (home)
 Street Address: _____ City / State / Zip: _____ Phone No.: _____ (work)
 Mailing Address: _____ City / State / Zip: _____ Email Address: _____

Marital Status Code: Single (1) Separated (S) Married (M) Widowed (W) Divorced (D)

Plan Choice: Large Group HMO Triple Option Conversion Other Choice(s) _____
 Small Group POS HDHP COBRA Plan Code# _____

II. IMPORTANT INFORMATION: You must provide complete information for yourself and each dependent you are enrolling, adding or terminating.

Children of eligible subscribers, age 0 to 26 may enroll. Children includes a son, daughter, stepchild, adopted child or foster child. Proof of Guardianship may be required. Dependent children age 26 to 30 are considered over-age dependents and may also be eligible to enroll provided they: (a) are unmarried; (b) have no dependents of their own; (c) reside in Florida or attend school; and (d) have no other health insurance. Dependent children age 26 or over that have a permanent mental or physical disability may also enroll (please attach a doctor's statement certifying disability status).

RELATION TO YOU	A	D	D	E	L	LAST NAME	FIRST NAME	MI	SOC. SEC. NO.	DATE OF BIRTH MM/DD/YYYY	SEX	PREVIOUS MEMBER Yes = Y No = N	FHCP MEDICAL RECORD # If Any	Enter appropriate code number from box on back (OPTIONAL)	
														Race	Ethnicity
Employee (18)	<input type="checkbox"/>	<input type="checkbox"/>									<input type="checkbox"/> M <input type="checkbox"/> F				
Spouse (01)	<input type="checkbox"/>	<input type="checkbox"/>									<input type="checkbox"/> M <input type="checkbox"/> F				
Life Partner (53)	<input type="checkbox"/>	<input type="checkbox"/>									<input type="checkbox"/> M <input type="checkbox"/> F				
Child (19)	<input type="checkbox"/>	<input type="checkbox"/>									<input type="checkbox"/> M <input type="checkbox"/> F				
Child (19)	<input type="checkbox"/>	<input type="checkbox"/>									<input type="checkbox"/> M <input type="checkbox"/> F				
Child (19)	<input type="checkbox"/>	<input type="checkbox"/>									<input type="checkbox"/> M <input type="checkbox"/> F				

III. LEGAL TERMS AND CONDITIONS:

1. I hereby apply for the coverage/membership that is selected on this form. My employer has selected health coverage through Florida Health Care Plan, Inc. (FHCP). I authorize the deduction from my earnings of the amount required to pay the premium associated with the FHCP health benefit plan that I have selected for myself and, if applicable, my dependents. I acknowledge that a change in coverage may affect the amount deducted from any wages (if any) for coverage and I hereby authorize such a change.
2. Covered individuals must meet all the group contract's requirements.
3. Coverage shall not become effective until FHCP accepts this application and assigns an effective date.
4. I agree to be bound by the group contract's terms and conditions and the Certificate of Coverage.
5. I agree to pay any fees including copayments, coinsurance, and deductibles associated with this coverage.
6. 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 FHCP 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, my plan may no longer qualify as an HSA compatible plan.
7. I agree that in the event of any controversy or dispute with FHCP, I and my dependents must exhaust the appeal processes in the benefit documents and Certificate of Coverage.
8. I understand that my employer is not an agent of FHCP. 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.
9. I authorize any other entity having health or personal identification information as to me or my dependents to release it to FHCP and its insurance agents for the purpose of administering coverage.
10. I understand information provided herein may be used for care, treatment and health care operations.
11. I understand that no agent can modify this application, waive the answers to any questions, or suggest or complete the answers hereto.
12. By providing your contact information, you confirm that you are the subscriber and/or authorized user of the phone number(s)/emails provided, you consent to receive texts, emails, and/or phone calls at the contact information from Florida Health Care Plan, Inc, their affiliates, and agents, including licensed insurance agents, including calls made using automated technologies and regardless of whether the number is listed on the national or state Do Not Call registry, and without regard to state or federal limitations on frequency of calls or messages. The types of calls and texts you consent to receive include messages about your plan and benefits, billing and invoicing, treatment, care, servicing your account, and healthcare-related and informational messages. You may revoke your consent at any time. Your consent is not required as a condition to make a purchase. Message and data rates may apply. Message frequency varies. Major carriers supported. Our Terms of Use and Privacy Policy also apply and are available online at www.fhcp.com.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM OR ANY APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

I certify that I read the statements and information on this form is true and complete to the best of my knowledge. 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.

Signature: _____ Date: _____

CODE BOX

Please enter the appropriate Code #(s) for each member being enrolled in the OPTIONAL box(es) on the reverse side of this form.

RACE:

- (7) - Unknown
 - (C) - White
 - (8) - Black
 - (E) - Other
 - (A) - Asian
 - (H) - Hispanic
 - (G) - North American Native
- ##### ETHNICITY:
- (L) - Hispanic or Latino
 - (N) - Non Hispanic or Latino

REASON FOR

- ##### CHANGE CODES:
- (C) - Divorce
 - (E) - Reduction in Hours
 - (J) - Plan Code change
 - (R) - Retired
 - (W) - Declined coverage
 - (0) - Other term reason
 - (1) - Term of Employment
 - (6) - Other coverage
 - (9) - Death