BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Health & Financial Enrollment Application

Please type or write clearly in black or blue ink.

Section A: Employer Information

Group Name: | Group #: | Division #: | Package #:

Effective Date of Coverage: | Date of Hire: | Location #: | Employee #: | Job Title:

Work Status: ☐ Actively at Work ☐ Cobra ☐ Retired | Retirement Date: | Paid: ☐ Hourly ☐ Salary ☐ Open Enrollment

Section B: Employee Information

Social Security #: | Last Name: | First Name: | M.I.: | Birth Date: | Sex: ☐ M ☐ F

Street Address: | Apt. #: | City: | State: | Zip:

County: | Phone: | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Physician Name / ID # *HMO only*: | Existing Patient: ☐ Yes ☐ No | Language of Preference: *optional - for data collection purposes only* ☐ English ☐ Spanish ☐ Other _____ ☐ Prefer not to answer

Ethnicity *optional* *Check all that apply:* ☐ Asian/Pacific Islander ☐ Black/African American ☐ Caribbean Islander ☐ Hispanic ☐ Native American ☐ White

Section C: Coverage Level and Plan Information

Employee Health Coverage Level: ☐ Employee ☐ *Employee & Spouse ☐ *Employee & One Dependent ☐ *Employee & Child(ren) ☐ Family
** When available*

☐ BlueOptions Plan # _____ ☐ BlueChoice (PPO) Plan # _____ ☐ BlueCare (HMO) Plan # _____ ☐ Other Plan # _____

☐ I am Refusing all Health Coverage at this time. I understand that if I decide to apply later coverage may not be available until the next open or special enrollment period. Signature: Date:

Section D: Flexible Spending Account Contributions *If offered by group and employee elects, below information is required for enrollment*

☐ I elect to contribute $_____ for the plan year to a **Health Care FSA** on a pre-tax basis.
☐ I wish to have my employer's contributions applied to the Health Care FSA *if applicable*
☐ I do not wish to participate in the Health Care FSA Program
Payroll Deduction Amt $:_____ | Effective Date:

☐ I elect to contribute $_____ for the plan year to a **Dependent Care FSA** on a pre-tax basis.
☐ I wish to have my employer's contributions applied to the Dependent Care FSA *if applicable*
☐ I do not wish to participate in the Dependent Care FSA Program
Payroll Deduction Amt $:_____ | Effective Date:

Payroll Frequency: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Bi-monthly ☐ Other

Section E: Dependent Information *Attach separate sheet, if additional space is needed, with dependent information, sign & date.*

Last Name: *(if different than employee)* First Name, M.I.	Social Security Number:	Birth Date:	Relation to You: Spouse (S)	Child (C)	Other (O)*	Sex (M or F)	Check if Disabled	Physician Name/ID *HMO only*	Existing Patient (Y/N)	Dependent: You Support	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 B C H N W
							☐			☐	☐	☐	A B C H N W
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* If you indicated "O" in "Relation to You" above for any dependents, please explain here:

Section F: 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 BCBSF plans) that will be in effect after this coverage begins? ☐ Yes ☐ No *BCBSF* 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.

Prior Heath Carrier Name: | Contract #: | Effective Date:

Prior Employee Hire Date: | Cancel Date: | List names of all family members that were covered, including yourself:

Section G: Acceptance of Health Coverage and/or FSA Participation

I have read, understand, and agree to the Acceptance of Coverage and/or Participation in the FSA Program Terms on the back of this form. Place a check in the applicable checkbox to elect Health coverage and/or FSA Participation. ☐ Health ☐ FSA

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: