Florida Health Care Plans®

An Independent Licensee of the Blue Cross and Blue Shield Association

1340 Ridgewood Ave., Holly Hill, FL 32117

PLEASE PRINT CLEARLY

Group Health Employee Application/Change Form

Please forward to: FHCP Enrollment Dept.

EMPLOYER USE ONLY: Group No: _____ Employer: _____ Phone: _____

Effective Date: _____ Hire Date: _____ Dept. Location: _____

ENROLLMENT:	CHANGE:	* REASON FOR CHANGE: Please check appropriate box or enter code number from box on back		
☐ New Enrollment (28)	☐ Add (021) ☐ Change (001)	☐ Marriage (32)	☐ Change of Address (43)	☐ Gain/Loss Other Coverage (33)
☐ Open Enrollment Plan Change (22)	☐ Terminate (024) ☐ Reinstate (025)	☐ Birth (02)	☐ Leave of Absence (37)	☐ Medicare/Medicaid Entitlement (D)
☐ Waive Coverage (26)	Eff. Date:_____/_____/_____	☐ Adoption/Placement (05)	☐ Workplace Change (43)	☐ Judgment/Court Order (31)

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** ☐ **SMALL GROUP** ☐ HMO ☐ POS ☐ Triple Option ☐ HDHP ☐ Conversion ☐ COBRA ☐ Other Choice(s)_____ **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 certifiying disability status).

RELATION TO YOU	A D 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	STUDENT = S or DISABLED = D	Enter appropriate code number from box on back (OPTIONAL) Race	Ethnicity	PRE-X DATES *FHCP USE ONLY*
Employee (18)	☐	☐						☐ M ☐ F						
Spouse (01)	☐	☐						☐ M ☐ F						
Life Partner (53)	☐	☐						☐ M ☐ F						
Child (19)	☐	☐						☐ M ☐ F						
Child (19)	☐	☐						☐ M ☐ F						
Child (19)	☐	☐						☐ M ☐ F						

III. CURRENT OR PRIOR HEALTH INSURANCE COVERAGE FOR THE LAST 12 MONTHS: (FOR ALL SMALL GROUP ENROLLEES OR LARGE GROUP LATE ENROLLEES)

FHCP must receive a copy or copies of a certificate of creditable coverage containing carrier and dates of previous coverage for each person to be enrolled; otherwise, pre-existing condition limitation may apply.

Health Insurance Company Name: _____ Customer Service Phone No.: _____ Original Effective Date: _____ Termination Date: _____

IV. CERTIFICATION AND AUTHORIZATION:

I authorize the deduction from my earnings of any amount that may be required to pay the premium associated with the Florida Health Care Plan, Inc. (FHCP) health benefit plan that I have selected for myself and, if applicable, my dependents. I agree to pay any subscription fees including copayments, coinsurance and deductibles associated with this coverage. I authorize any health care professional, health care facility, insurer, HMO, the Medical Information Bureau, or any other entity having health or personal identification information as to me or my dependents to release it to FHCP, its contracted and staff providers, claims administration personnel, utilization/peer review organizations, reinsurer, and insurance agents. In addition, information concerning health care advice, treatment, or supplies provided to me or my dependents related to coverage under the FHCP health benefit plan I have selected. I understand that this information may be used for coordinating health care, health plan operations, evaluation and administration of claims, and business requirements imposed on FHCP by Federal or State law. I further understand that this authorization may be withdrawn by me at any time as applicable according to my groups' contract, but will otherwise continue to be valid during the entire term of my enrollment in FHCP. I understand that a facsimile of this signed Authorization and Certification shall be as valid as the original. I certify that I read the statements on this form or that they have been read to me, and that all the information contained in Section II was provided by me and is true and complete to the best of my knowledge. I understand that any material misrepresentation or material omission contained herein may be used to reduce or deny a claim or service or void the contract. I further understand that no agent can modify this application, waive the answers to any questions, or suggest or complete the answers hereto. 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.

Signature: _____ Date: _____

FHCP OFFICE USE ONLY:
Plan Code
Rider Code(s)
Group No.
Coverage Type
Approved By
Date

WHITE - FHCP ENROLLMENT; YELLOW - EMPLOYER; PINK - EMPLOYEE

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
- (B) – 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:

- (07) – Termination of Benefits
- (08) – Employment Terminated
- (AB) – Dissatisfied with Services
- (59) – Non-payment
- (13) – Moving Out-of-Area
- (14) – Other Coverage
- (07) – Employer Cancels Coverage
- (03) – Death
- (08) – Termination of Employment
- (AI) – No Reason Given
- (01) – Divorce
- (04) – Retirement
- (06) – Strike
- (09) – COBRA