LAKE COUNTY
FLORIDA

Lake County Board of County Commissioners
Health Coverage Enrollment or Change Form

Offered through Blue Cross and Blue Shield of Florida

Please write/type clearly in black or blue ink.

☐ **Termination or Refusal of Any / All Coverage** *Complete and sign this box only.*

I understand that if I decide to apply at a later time, this coverage may not be available until the next open enrollment or special enrollment period.

Print Name ______________________ Social Security # ____-____-____

Signature of Applicant/Employee ______________________ Date ________

☐ **Enrollment** *Start with Section 2 and complete applicable sections.*

☐ **Change in Coverage or Personal Information** *Start with Section 1 and complete applicable sections.*

INTERNAL USE ONLY

Employer Group Name Lake County Board of County Commissioners Group # 64550 Division ________

Open Enrollment? Yes No Employee # ________ Location # ________

Date of Hire *(mm/dd/yyyy)* ___/___/____ Effective Date *(mm/dd/yyyy)* ___/___/____ Retirement Date *(mm/dd/yyyy)* ___/___/____

Work Status:
___ Actively at Work
___ Retired
___ COBRA

Section 1: Reason for Change *Be sure to sign and date Section 4 to authorize change.*

Change in Coverage

___ Terminate Coverage ___ Dependent Coverage ___ Plan Coverage ___ Provider/Facility Change

___ Other (Explain): ______________________

Change in Personal Information *Be sure you completed Section 2 # 1-8 with new information.*

___ Name Former Name: ____________ New Name: ____________

___ Address

Reason for Change Date of Event: ___/___/____

___ Adoption ___ Birth ___ Death ___ Divorce ___ Loss of Coverage ___ Marriage

___ Dependent (Up to Age 26)[1] ___ Over-Aged Dependent (Up to Age 30)[2] ___ Terminate Employment

___ Other *(explain)*: ______________________

[1] *Is under the age of 26 or until the end of the calendar year in which he/she turns 26.*
[2] *Has reached the end of the calendar year in which he or she becomes 26, but has not reached the end of the calendar year in which he or she becomes 30.*

Section 2: Employee Information

1. Social Security # ____-____-____ **Be sure to place your social security number at the top of pages 2 & 3.*

2. Name ______________________ (Last, First, M.I.) 3. Job Title ____________

4. Mailing Address ______________________ (Street Address, Apt. #)

5. City ____________ State ____ Zip ______-____ 6. County ____________

7. Phone (____) ____________ 8. Date of Birth ___/___/____ 9. Gender M F

10. You are? ___Single ___Married ___Divorced ___Widowed

11. Optional Information for data only. It will not be used for determining eligibility or claim payment.

Ethnicity/Race *Check all that apply*

___Asian or Pacific Islander ___Black or African American ___Caribbean Islander ___Hispanic ___Native American ___White

Primary language spoken:

___Creole ___English ___French ___Portuguese ___Russian ___Spanish ___Other: ____________

Social Security # ______ - ______ - ______

Section 3: Health Coverage

12. **Health**

___ BlueChoice *(PPO)* Plan # ____________

___ BlueCare *(HMO offered by Health Options, Inc.)* Plan # ____________

Health Coverage for:

Check one and complete #16 and 17(HMO only) for eligible dependents.

___ Employee ___ Family

13. **Other Insurance Information** *(This section must be completed for claims processing)*

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

___ Health, if BCBSF, contract # ____________ ___ Medicare # ____________ ___ Pharmacy ___ Dental

___ Other Coverage *(Attach copy of card)* ____________

Name Policy Number Contact Information

14. **Prior Coverage Information**

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 had any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable Coverage.

Health Carrier Name ____________ Contract Number ____________

Effective Date ____________ Prior Employee Hire Date ____________ Cancel Date ____________

Reason ____________

State full names of all family members that were covered, including yourself. *Attach separate sheet if needed, sign and date.*

____

____

15. **Select Coverage for Eligible Dependents**

Add Health For: ___ Spouse ___ Child 1 ___ Child 2 ___ Child 3 ___ Other Dependent

Remove Health For: ___ Spouse ___ Child 1 ___ Child 2 ___ Child 3 ___ Other Dependent

16. **Information of Eligible Dependents to Be Covered**

Last name required if different from yours. Attach separate sheet, if needed, with additional dependents, sign and date.

First Name, M.I., Last Name	Social Security #	Date of Birth	Gender *(Circle One)*	Disabled? *(Circle One)*	Mark "X" if:			
					You Support	Lives with you	Student	Over-aged Dependent*
Spouse			M F	Y N				
Child 1			M F	Y N	☐	☐	☐	☐
Child 2			M F	Y N	☐	☐	☐	☐
Child 3			M F	Y N	☐	☐	☐	☐
Other			M F	Y N	☐	☐	☐	☐
Relationship								

* *Has reached the end of the calendar year in which he or she becomes 26, but has not reached the end of the calendar year in which he or she becomes 30 who: 1) is unmarried and does not have a dependent and 2) is a Florida resident or full-time or part-time student and 3) is not enrolled in any other health coverage policy or plan and 4) not entitled to benefits under Medicare.*

Social Security # ____ - ____ - ____

17. **BlueCare HMO Primary Care Physician** *For PCP ID#s, refer to the provider directory at www.bcbsfl.com*

	Physician	PCP ID#	Current patient (Circle One)
Physician for Self			Y N
Physician for Spouse			Y N
Physician for Child 1			Y N
Physician for Child 2			Y N
Physician for Child 3			Y N
Other Dependent			Y N

Section 4: Acceptance of Coverage

I hereby apply for the coverage/membership or apply for the change in coverage/membership or personal information that is selected on this form. My employer has selected the coverage/membership through Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") or Health Options, Inc. ("HOI").

I authorize my employer to deduct from my earnings my premium contribution, if any. 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 or HOI accepts this application and assigns an effective date; and 4. If I am not actively at work on my proposed effective date of any coverage, my effective date for such coverage may be deferred; it may be deferred until the date I return to active work. I understand that this application is hereby made part of the group contract.

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.

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

I acknowledge that BCBSF 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 or HOI coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period. Also, for BCBSF coverage, I may be required to furnish evidence of insurability. 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.

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 of Applicant/Employee ______________________ Date: ________

For enrollment or changes in coverage.

Signature of Employer Representative ______________________ Date: ________

Health Options and Blue Cross and Blue Shield of Florida are Independent Licensees of the Blue Cross and Blue Shield Association.