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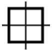


Complete only if **Presently Insured** by Blue Cross and Blue Shield of Florida, Inc. or Health Options, Inc.

CHANGES MUST BE MADE WITHIN DEFINED ELIGIBILITY PERIOD.

Member Status Change Request

1. Type of Change
- ☐ Change Type of Coverage
- ☐ Name Change
- ☐ Address Change
- ☐ Add Dependent
- ☐ Delete Dependent
- ☐ E-Mail Address Change
- ☐ Change Primary Care Physician
- ☐ Delete Health Coverage
- ☐ Delete Life Coverage
- ☐ Terminate Coverage
- ☐ Other ____________________

EFFECTIVE DATE OF CHANGE ____________________

2. Type Coverage Requested
- ☐ Employee
- ☐ Employee/Spouse*
- ☐ Employee/Child(ren)*
- ☐ Employee/Family
- ☐ Health & Life
- ☐ Health Only
- ☐ Life Only
- ☐ Dental

*only available where offered

3. Reason for Change
- ☐ Marriage**
- ☐ Death**
- ☐ Terminate Employment**
- ☐ Divorce**
- ☐ Birth**
- ☐ Adoption**
- ☐ Overage Dependent
- ☐ Moved from Service Area
- ☐ Leave of Absence/Layoff
- ☐ Return of Alternate Insurance
- ☐ Open Enrollment
- ☐ Other ____________________

**DATE OF EVENT ____________________

General Information

4. Name of Group Employer	5. Group Number	6. Division Number	7. Package Number
8. Insured's Name (Last Name, First Name, Middle Initial)	9. Insured's Contract Number (Social Security Number)		

10. List Eligible Family Members to be Covered

A copy of the court order must be attached for dependents in court-ordered custody or guardianship of the Certificateholder/Covered Employee. (PLEASE PRINT) If more space is required, attach a separate sheet with additional information.

Additions	First Name and Middle Initial Last Name (if not the same)	Social Security Number	Sex	Birth Date Mo. Day Yr.	Check if: Disabled	Supported by you &	Living with you or	Full-Time/ Part-Time Student	11. Primary Care Physician Name (Last Name, First Name)	Primary Care Physician Number	Current Patient Y	N
Add Spouse			☐ M ☐ F									
Add Dependent Child			☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No				
Add Dependent Child			☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No				
Add Dependent Child			☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No				
Add Dependent			☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No				

12. Deletions and/or Changes to Coverage

Name(s) to be deleted (Last, First, Middle, Initial)	Date of Birth	Name(s) to be deleted (Last, First, Middle, Initial)	Date of Birth
A)		C)	
B)		D)	

13. Reason for Deletion ☐ Age ☐ Divorce ☐ Marriage ☐ Death

☐ Other - Please Explain:

☐ Address Change	14. New Address (Street, City, County, State, Zip)	15. Phone Number
☐ E-Mail Change	16. New E-Mail Address	
☐ Name Change	17. Change Name From: To:	

	18. Name of Member	19. Date of Birth	20. New Primary Care Physician (Last Name, First Name)	Primary Care Physician Number
☐ Change Primary Care Physician				
☐ Other				

Other Carrier Liability Information – THIS SECTION MUST BE COMPLETED

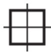
21. On the day this coverage begins, will you or any family members enrolling in this plan be covered by any other group or individual health insurance or Medicare? ☐ Yes ☐ No
If yes, fill out the appropriate section(s) below. If more space is required, attach a separate sheet with additional information.

22. Health	23. ☐ Additional Health OR ☐ Dental	24. Medicare	
Insured's / Member's Name — Date of Birth	Insured's / Member's Name — Date of Birth	Beneficiary Name	Beneficiary Name
Employment Status — Name of Employer ☐ Active ☐ Retired	Employment Status — Name of Employer ☐ Active ☐ Retired	Entitlement Reason ☐ Age 65 or older	Entitlement Reason ☐ Age 65 or older
Policy# — Effective Date — Type of Coverage ☐ Single ☐ Family	Policy# — Effective Date — Type of Coverage ☐ Single ☐ Family	☐ End Stage Renal Disease ☐ Other Disability	☐ End Stage Renal Disease ☐ Other Disability
Name of Insurance Company — Phone # ( )	Name of Insurance Company — Phone # ( )	Medicare HIC Number	Medicare HIC Number
City, State and Zip Code of Claims Center	City, State and Zip Code of Claims Center	Part A Effective Date	Part A Effective Date
Does the above insurance cover "all" family members including yourself? ☐ Yes ☐ No If no, please list the names of all dependents not covered:	Does the above insurance cover "all" family members including yourself? ☐ Yes ☐ No If no, please list the names of all dependents not covered:	Part B Effective Date	Part B Effective Date

25. Acceptance of Any Coverage / Membership – I have read and understand the Change Authorization on the reverse side of this form.

Signature of Certificateholder/Covered Employee ____________ **Date** ____________ **Signature of Employer Representative** ____________ **Date** ____________

Membership & Billing - White SGEO - Pink FCL - Yellow OPL - Green Client - White



Change Authorization

I hereby authorize the changes to my Blue Cross Blue Shield of Florida, Inc. ("BCBSF") and/or Health Options, Inc. ("HOI") contract. I understand and agree that the changes will not be effective until this application is accepted by BCBSF and/or HOI. I authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution or person that has records or knowledge of me or my eligible family members to give such information to BCBSF and/or HOI (or other affiliated carrier). This release specifically includes, but is not limited to, authorization to release any and all medical records and information associated with reference to) certain conditions. I authorize BCBSF and/or HOI to exchange benefit information with any insurance company, organization or individual to determine the applicability of the coordination of benefits provision for myself and my eligible family members. When an overpayment has been made, BCBSF and/or HOI is authorized to recover the excess payment from the individual, insurance company or organization to whom payment has been made. I authorize BCBSF and/or HOI, at their sole discretion and consistently with applicable laws and regulations, to use and disclose financial and health information obtained about me and/or my eligible family members for treatment, payment, and/or health care operations purposes. I represent that my statements on this application are true and complete and understand and agree that any misstatements may result in denial of benefits and/or termination of coverage.

FRAUD NOTICE: 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.