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

Health Change Application

MCMS, Inc.-Insurance Trust Fund
Duval Associate Members

Please type or write clearly in black or blue ink.

Section A: Current Information

Group Name:		**Group #:**	**Division #:**
Employee Name: (Last, First Name, M.I.)	**Social Security #:**	**Effective Date of Coverage:**	**Date of Event:**

Section B: Coverage Change Information

Reason for Change:

- ☐ Adoption
- ☐ Birth
- ☐ Death
- ☐ Divorce
- ☐ Leave of Absence
- ☐ Loss of Coverage
- ☐ Marriage
- ☐ Medicare Eligible
- ☐ Ineligibility of Dependent Child
- ☐ Reduction of Hours
- ☐ Retirement
- ☐ Return of Alternate Insurance
- ☐ Termination

Change Request Type:	☐ New Name:	
	☐ New Address:	☐New Phone #:

Plan Coverage Type Requested: ☐Add Health (make selection below) ☐Delete Health ☐Change Plan (make selection below)	
Employee Plan Choices:	☐**B** ☐**C** ☐**I** ☐**L** (HSA Plans) ☐**G** ☐**H** ☐**M**
Physician (owner/partner) Plan Choices:	☐**D** ☐**E** (HSA Plans) ☐**F** ☐**K**
Coverage Level Requested:	☐Employee ☐Family
☐Dependent Change *Complete Section C*	☐ Other Change
Primary Care Physician Name (First, Last): *HMO Only (Plan L & Plan M)*	Existing Patient: *HMO Only* ☐Yes ☐No

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

Last Name *(if different than employee),* **First Name, M.I.**	**Social Security Number:**	**Birth Date:**	**Relation to You**			**Sex (M or F)**	**Check if Disabled**
			Spouse (S)	**Child (C)**	**Other (O)***		

List the name of each dependent listed above that is married or has dependent child(ren) or lives outside of Florida.

*If you indicated “O” in “Relation to You” above for any dependents, please explain here:

Section D: 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?

☐ No ☐ Yes BCBSF Contract#________________________________

Section E: Change Authorization

Employee Signature: Date:

Employer Signature: Date: