



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, Termination, Reduction of Hours, Retirement, Return of Alternate Insurance
Change Request Type: New Name, New Address, New Phone #
Plan Coverage Type Requested: Add Health, Delete Health, Change Plan
Employee Plan Choices: B, C, I, L, G, H, M
Physician (owner/partner) Plan Choices: D, E, F, K
Coverage Level Requested: Employee, Family
Primary Care Physician Name (First, Last): Existing Patient: HMO Only

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

Table with columns: 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

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: