Section A: Employer Information *Please type or print clearly in black or blue ink*

1. **Employer:**				2. **Group No**:
3. Effective Date of coverage:	4. Location No:	5. Date of Hire:	6. Job Title:	7.Soc Sec#

Section B: Employee Information *(Note: If additional space is needed, please print on separate sheet, sign and date)*

8. Last Name:	First:	M.I.

9. Date of Birth (MM/DD/YYYY):	10. Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated	11. Gender: ☐Female ☐Male

12. Mailing Address:	13. Apt #:	14. City:	15. State	16. Zip:

17. County:	18. Home Phone with Area Code:	19. Cell Phone:

Section C: Coverage Level and Plan Information

20. Employee Health Coverage Level: (Check box that applies) ☐Employee Only ☐Family	21. **EMPLOYEE PLAN CHOICES:** ☐Plan B ☐Plan C ☐Plan I ☐Plan L	HSA Plans	☐Plan G ☐Plan H ☐Plan M
22. Physician Health Coverage Level: (Check box that applies) ☐Employee Only ☐Family	23. **PHYSICIAN (OWNER/PARTNER) PLAN CHOICES:** ☐Plan D ☐Plan E	HSA Plans	☐Plan F ☐Plan K
24. Primary Care Physician Name (First, Last): *HMO Only (Plan L & Plan M)*			25. Existing Patient: *HMO Only* ☐Yes ☐No

26. ☐ I am refusing all Health Coverage at this time. I understand that if I decide to apply later, coverage may not be available until any qualified special enrollment period.

Signature:____ Date: ___________________

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

27. Last Name: (if different than employee) First, Name, M.I.	Social Security Number	Date of Birth	Relation to You							
			(S) Spouse	(C) Child	(O)* Other	M/F Sex	Check if Disabled	You Support	Lives with You	Is a Student
							☐			
							☐			
							☐			
							☐			
							☐			

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

Section E: Other Health Insurance Information

28. 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 BCBSF Contract # ____________________ Medicare#__________________ Pharmacy/Medicare ID#___________________

Section F: Acceptance of Health Coverage

29. **Request for Signature and Certification:** *I have read and understand the "limitations and Exclusions" on the reverse side of this enrollment form.* I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change. I agree to be bound to the terms and conditions of the master policy.

30. Signature:	31. Date:

Section G: Acceptance of Any Coverage/Membership. Read before Signing on the Front of this Form.

Plan Coverage Terms

I hereby apply for the coverage/membership that is selected on this form. My employer has selected health through Florida Blue and/or HMO coverage through Florida Blue HMO.

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 Florida Blue and/or Florida Blue HMO accepts this application and assigns an effective date.

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.

If I am enrolling in a high-deductible health plan designated for use with a Health Savings Account (HSA) under Internal Revenue Service Code section 223, I recognize and authorize Florida Blue to exchange certain limited information obtained from this application with its preferred financial partner(s) for the purposes of initial enrollment in, and administration of, HSAs.

General Terms

I AGREE that in the event of any controversy or dispute between Florida Blue and/or Florida Blue HMO, 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 Florida Blue and/or Florida Blue HMO. 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 Florida Blue and/or Florida Blue HMO to recover the excess from any person or entity that received it.

I acknowledge that Florida Blue and/or Florida Blue HMO coverage/membership is contingent upon the complete, accurate disclosure of the information requested on this form.

I acknowledge that, if I apply for Florida Blue and/or Florida Blue HMO coverage/membership later, coverage/membership may not be available at a later date. 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.