

CITY OF VENICE

Group Health Insurance Enrollment/Change Form

Section 1: Personal Information					
Employee Name (Last, First, MI)		Social Security No.		Birthdate	
				Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Home Street Address		City		State	Zip Code
				Telephone No.	
Section 2: New Enrollment					
<input type="checkbox"/> DECLINE		Coverage Level: <u>Complete Sections 5 and 6 for Empl/Ret Only and Sections 4A, 4B, 5, & 6 if electing dependent coverage</u>			Effective Date:
		<input type="checkbox"/> Employee/Retiree Only	<input type="checkbox"/> Employee/Retiree + 1	<input type="checkbox"/> Family	
Section 3: Change					
<input type="checkbox"/> CHANGE COVERAGE to <u>Complete Sections 5 and 6 for Empl/Ret Only and Sections 4A, 4B, 5, & 6 if electing dependent coverage</u>					Effective Date:
					<input type="checkbox"/> Employee/Retiree Only
					<input type="checkbox"/> Employee/Retiree + 1
					<input type="checkbox"/> Family
<input type="checkbox"/> DROP ALL COVERAGE		<input type="checkbox"/> DROP DEPENDENT <u>Must complete Section 4A</u>		<input type="checkbox"/> ADD DEPENDENT <u>Must complete Sections 4A, 4B, 5, & 6</u>	
Section 4A: Dependent Information (Attach additional sheet of paper, if necessary. Sign and date it.)					
<input type="checkbox"/> ADD	First Name, M.I., Last Name	Social Security No.		Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> DROP					SPOUSE
<input type="checkbox"/> ADD	First Name, M.I., Last Name	Social Security No.		Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> DROP					CHILD
<input type="checkbox"/> ADD	First Name, M.I., Last Name	Social Security No.		Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> DROP					CHILD
<input type="checkbox"/> ADD	First Name, M.I., Last Name	Social Security No.		Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> DROP					CHILD
<input type="checkbox"/> ADD	First Name, M.I., Last Name	Social Security No.		Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> DROP					CHILD
Section 4B: List names of each dependent included above who is married and/or has dependent child(ren) and/or lives outside of Florida.					
Section 5: Other Coverage (Attach additional sheet of paper, if necessary, Sign and date it.)					
Do you or any dependents listed above have any other insurance coverage (including BCBS) that will continue to be in effect after this coverage begins? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If yes for each dependent with other coverage, please provide:					
Name of Dependent with Other Coverage		Coverage Start Date	Group Policy No.	Name & Address of Insurance Co.	Coverage End Date
Name of Dependent with Other Coverage		Coverage Start Date	Group Policy No.	Name & Address of Insurance Co.	Coverage End Date
Name of Dependent with Other Coverage		Coverage Start Date	Group Policy No.	Name & Address of Insurance Co.	Coverage End Date
Section 6: Prior Coverage Complete, if in the past 12 months, you or your dependents enrolling have any health coverage that this coverage replaces or attach a Certificate of Creditable Coverage.					
Prior Health Carrier		Coverage Start Date	Group Policy No.	Address of Insurance Co.	
Name of Insured Member			Member Birthdate	Member Social Security No.	Coverage End Date
Section 7: Affirmation/Declination of Coverage					
<input type="checkbox"/> I wish to apply for coverage as indicated above. I have read and accept the "Acceptance of Coverage" on the reverse side of this form. I affirm all information presented above is true and correct to the best of my knowledge.			<input type="checkbox"/> I am refusing all health insurance coverage at this time. I understand that if I decide to apply at a later time, coverage may not be available until the next open enrollment.		
Section 8: Signature					
Employee Signature					Date

Acceptance of Coverage

Plan Coverage Terms

I hereby apply for the coverage/membership that is selected on this form. My employer has selected the coverage/membership through Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") and/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 and/or HOI 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 (HAS) under Internal Revenue Service Code section 223, I recognize and authorize BCBSF 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.

I understand that if I am enrolling in an HAS qualified High Deductible Health Plan and I elect to receive Prior Carrier Credit under Florida law, my plan may no longer qualify as an HAS compatible plan.

General Terms

I AGREE that in the event of any controversy or dispute between BCBSF and/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 and/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 under the group contract.

When an overpayment is made, I authorize BCBSF and/or HOI to recover the excess from any person or entity that received it.

I acknowledge that BCBSF and/or HOI coverage/membership is contingent upon the complete, accurate disclosure of the information on this form.

I acknowledge that if I apply for BCBSF and/or HOI coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period. 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.