



Section A: Current Information

Group Name: Group #: Division #: Package #: Employee Name: Social Security #: Effective Date of Coverage: Date of Event:

Section B: Coverage Change Information

Reason for Change: Adoption, Death, Leave of Absence/Layoff, Moved from Service Area, Open Enrollment, Section 125, Marriage, Birth, Over-Aged Dependent, Terminate Employment, Return of Alternate Insurance, Loss of Coverage, Divorce, Location, Employee #, Other. Change Request Type: New Name, New Address, New Physician Name/ID, New Phone #.

Plan Coverage Type Requested: Add Health, Delete Health, Change Plan. Coverage Level Requested: Employee, Employee & Spouse, Employee & One Dependent, Employee & Children, Family. Dependent Change, FSA Change, Other Change.

Section C: Flexible Spending Account (FSA) Changes

Add Health Care FSA, Add Dependent Care FSA. I wish to Terminate and/or Stop Pay my FSA Health Care Program with a Final Payroll Deduction Date of: I wish to Terminate and/or Stop Pay my FSA Dependent Care Program with a Final Payroll Deduction Date of: I wish to Change the Annualized Amount of my Health Care FSA to: \$ I wish to Change the Annualized Amount of my Dependent Care FSA to: \$ Payroll Deduction Amount \$, Effective Date: I wish to change my Payroll Frequency to: Weekly, Bi-weekly, Monthly, Bi-monthly, Other.

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

Table with columns: (A) Add (D) Delete (C) Change, Last Name, Social Security Number, Birth Date, Relation to You (Spouse, Child, Other, Sex, Check if Disabled), Physician Name/ID, Existing Patient (Y/N), You Support, Lives With You, Is a Student, Ethnicity (A, B, C, H, N, W).

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

Section E: 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? Yes No BCBSF Contract # Medicare # Pharmacy/Medicare D # Complete the following only if this is the first time you or your dependents: (1) are enrolling for health insurance with this employer; (2) currently have health coverage; and/or (3) have any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable Coverage. Prior Health Carrier Name: Contract #: Effective Date:

Prior Employee Hire Date: Cancel Date: List names of all family members that were covered, including yourself:

Section F: Change Authorization and/or FSA Participation

I have read, understand, and agree to the Change Authorization and/or Participation in the FSA Program Terms on the back of this form. 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.

Employee Signature: Date: Employer Signature: Date:

Plan Coverage Terms

I hereby authorize the changes to my Blue Cross Blue Shield of Florida, Inc. ("BCBSF") and/or Health Options, Inc. ("HOI") contract that is selected on this form. I understand and agree that the changes will not be effective until this application is accepted by BCBSF and/or HOI.

I authorize my employer to deduct from my earnings my premium contribution, if any, including any additional amounts required as a result of the changes indicated on this Health & Financial Change Application. 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 (HSA) 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 I cannot have both, an FSA and an HSA through BCBSF as it conflicts with IRS code.

FSA Terms

If my employer offers an FSA and I elect, through the changes on the reverse side of this form, to participate through payroll deduction. I understand and agree to the following:

1. My FSA election will remain in effect for the duration of the plan year and to participate in succeeding years, I must complete a new election form;
2. I cannot suspend, increase or decrease my payroll deductions during the plan year unless, I experience a valid change in status, as defined in the Plan Documents and in accordance with Federal Tax Law;
3. I cannot submit claims incurred prior to the date that I joined the FSA Program or after the plan year ends (unless, the employer's Plan Document allows for carry over as prescribed in Federal Internal Revenue Service rules);
4. My employer is not responsible for any tax liabilities that I may incur as a result of my participation in the FSA Program; and
5. I authorize payroll deductions for the total amount(s) indicated into my Flexible Spending Account(s).

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/membership 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 requested 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.