



Complete only if **Presently Insured** by Blue Cross and Blue Shield of Florida, Inc. or Health Options, Inc.
CHANGES MUST BE MADE WITHIN DEFINED ELIGIBILITY PERIOD.

Member Status Change Request

<p>1.Type of Change</p> <input type="checkbox"/> Change Type of Coverage <input type="checkbox"/> Change Primary Care Physician <input type="checkbox"/> Name Change <input type="checkbox"/> Delete Health Coverage <input type="checkbox"/> Address Change <input type="checkbox"/> Delete Life Coverage <input type="checkbox"/> Add Dependent <input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Other _____ <input type="checkbox"/> E-Mail Address Change EFFECTIVE DATE OF CHANGE _____	<p>2.Type Coverage Requested</p> <input type="checkbox"/> Employee <input type="checkbox"/> Health & Life <input type="checkbox"/> Employee/Spouse* <input type="checkbox"/> Health Only <input type="checkbox"/> Employee/Child(ren)* <input type="checkbox"/> Life Only <input type="checkbox"/> Employee/Family <input type="checkbox"/> Dental *only available where offered	<p>3.Reason for Change</p> <input type="checkbox"/> Marriage** <input type="checkbox"/> Overage Dependent <input type="checkbox"/> Death** <input type="checkbox"/> Moved from Service Area <input type="checkbox"/> Terminate Employment** <input type="checkbox"/> Leave of Absence/Layoff <input type="checkbox"/> Divorce** <input type="checkbox"/> Return of Alternate Insurance <input type="checkbox"/> Birth** <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Adoption** <input type="checkbox"/> Other _____ **DATE OF EVENT _____
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General Information

4. Name of Group Employer	5. Group Number	6. Division Number	7. Package Number
8. Insured's Name (Last Name, First Name, Middle Initial)	9. Insured's Contract Number (Social Security Number)		

10. List Eligible Family Members to be Covered

A copy of the court order must be attached for dependents in court-ordered custody or guardianship of the Certificateholder/Covered Employee. (PLEASE PRINT) If more space is required, attach a separate sheet with additional information.

Additions	First Name and Middle Initial Last Name (if not the same)	Social Security Number	Sex	Birth Date Mo. Day Yr.	Disabled	Check if:			11. Primary Care Physician Name (Last Name, First Name)	Primary Care Physician Number	Current Patient	
						Supported by you	& Living with you	Full-Time/Part-Time Student			Y	N
Add Spouse			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Add Dependent Child			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Add Dependent Child			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Add Dependent Child			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Add Dependent			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				

12. Deletions and/or Changes to Coverage

Name(s) to be deleted (Last, First, Middle, Initial) A)	Date of Birth	Name(s) to be deleted (Last, First, Middle, Initial) C)	Date of Birth
B)		D)	

13. Reason for Deletion Age Divorce Marriage Death

Other - Please Explain:

<input type="checkbox"/> Address Change	14. New Address (Street, City, County, State, Zip)	15. Phone Number
<input type="checkbox"/> E-Mail Change	16. New E-Mail Address	
<input type="checkbox"/> Name Change	17. Change Name	
	From:	To:
<input type="checkbox"/> Change Primary Care Physician	18. Name of Member	19. Date of Birth
		20. New Primary Care Physician (Last Name, First Name)
<input type="checkbox"/> Other		Primary Care Physician Number

Other Carrier Liability Information – THIS SECTION MUST BE COMPLETED

21. On the day this coverage begins, will you or any family members enrolling in this plan be covered by any other group or individual health insurance or Medicare? Yes No
 If yes, fill out the appropriate section(s) below. If more space is required, attach a separate sheet with additional information.

22. Health	23. <input type="checkbox"/> Additional Health OR <input type="checkbox"/> Dental	24. Medicare	
Insured's / Member's Name Date of Birth	Insured's / Member's Name Date of Birth	Beneficiary Name	Beneficiary Name
Employment Status Name of Employer	Employment Status Name of Employer	Entitlement Reason	Entitlement Reason
<input type="checkbox"/> Active <input type="checkbox"/> Retired	<input type="checkbox"/> Active <input type="checkbox"/> Retired	<input type="checkbox"/> Age 65 or older	<input type="checkbox"/> Age 65 or older
Policy# Effective Date Type of Coverage	Policy# Effective Date Type of Coverage	<input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> End Stage Renal Disease
<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Other Disability	<input type="checkbox"/> Other Disability
Name of Insurance Company Phone #	Name of Insurance Company Phone #	Medicare HIC Number	Medicare HIC Number
()	()		
City, State and Zip Code of Claims Center	City, State and Zip Code of Claims Center	Part A Effective Date	Part A Effective Date
Does the above insurance cover "all" family members including yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list the names of all dependents not covered:	Does the above insurance cover "all" family members including yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list the names of all dependents not covered:	Part B Effective Date	Part B Effective Date

25. Acceptance of Any Coverage / Membership – I have read and understand the Change Authorization on the reverse side of this form.

Signature of Certificateholder/Covered Employee	Date	Signature of Employer Representative	Date
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Change Authorization

I hereby authorize the changes to my Blue Cross Blue Shield of Florida, Inc. ("BCBSF") and/or Health Options, Inc. ("HOI") contract. I understand and agree that the changes will not be effective until this application is accepted by BCBSF and/or HOI. I authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution or person that has records or knowledge of me or my eligible family members to give such information to BCBSF and/or HOI (or other affiliated carrier). This release specifically includes, but is not limited to, authorization to release any and all medical records and information associated with reference to) certain conditions. I authorize BCBSF and/or HOI to exchange benefit information with any insurance company, organization or individual to determine the applicability of the coordination of benefits provision for myself and my eligible family members. When an overpayment has been made, BCBSF and/or HOI is authorized to recover the excess payment from the individual, insurance company or organization to whom payment has been made. I authorize BCBSF and/or HOI, at their sole discretion and consistently with applicable laws and regulations, to use and disclose financial and health information obtained about me and/or my eligible family members for treatment, payment, and/or health care operations purposes. I represent that my statements on this application are true and complete and understand and agree that any misstatements may result in denial of benefits and/or termination of coverage.

FRAUD NOTICE: 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.