BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Health Enrollment Application

Please type or write clearly in black or blue ink.

Section A: Current Information

Group Name:	Group #:	Division #:	Package #:
Bay County Board of Commission	45444		

Effective Date of Coverage:	Date of Hire:	Location #:	Employee #:	Job Title:

Work Status: ☑ Actively at Work ☐ Cobra ☐ Retired | Retirement Date: | Paid: ☐ Hourly ☐ Salary ☐ Open Enrollment

Section B: Employee Information

Social Security #:	Last Name:	First Name:	M.I.:	Birth Date:	Sex: ☐ M ☐ F

Street Address:	Apt. #:	City:	State:	Zip:

County: | Phone: | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Physician Name / ID # *HMO only:* | Existing Patient: ☐ Yes ☐ No | Language of Preference: *optional - for data collection purposes only* ☐ English ☐ Spanish ☐ Other_____ ☐ Prefer not to answer

Ethnicity *optional* *Check all that apply:* ☐ Asian/Pacific Islander ☐ Black/African American ☐ Caribbean Islander ☐ Hispanic ☐ Native American ☐ White

Section C: Coverage Level and Plan Information

Employee Health Coverage: ☐ Employee ☐ *Employee & Spouse ☐ *Employee & One Dependent ☐ *Employee & Child(ren) ☐ Family
When available

[redacted] | ☐ Blue Options #03160 Hi Ded-$1300-Single | ☐ Blue Options #03161 Hi Ded-$2600-Family

☐ I am Refusing all Health Coverage at this time. I understand that if I decide to apply later coverage may not be available until the next open or special enrollment period. Signature: Date:

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

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	Physician Name/ID *HMO only*	Existing Patient (Y/N)	Dependent: You Support	Lives With You	Is a Student	Ethnicity *optional* *Circle all that apply.* A) Asian/Pacific Islander B) Black/African American C) Caribbean Islander H) Hispanic N) Native American W) White
							☐			☐	☐	☐	A B C H N W
							☐			☐	☐	☐	A B C H N W
							☐			☐	☐	☐	A B C H N W
							☐			☐	☐	☐	A B C H N W

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 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:

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.

Signature: Date: