CITY OF VENICE
Group Health Insurance Enrollment/Change Form

Section 1: Personal Information

Employee/Retiree Name (Last, First, MI)	Social Security No.	Birthdate		Gender ☐ M ☐ F
Home Street Address	City	State	Zip Code	Telephone No.

Section 2: New Enrollment

☐ **DECLINE**	Coverage Level: ***Complete Sections 5 and 6 for Individual Only and Sections 4A, 4B, 5, & 6 if electing dependent coverage*** ☐ Individual Only ☐ Individual + 1 ☐ Family	Effective Date:

Section 3: Change

☐ **CHANGE COVERAGE to** ***Complete Sections 5 and 6 for Empl/Ret Only and Sections 4A, 4B, 5, & 6 if electing dependent coverage*** ☐ Individual Only ☐ Individual + 1 ☐ Family	Effective Date:

☐ **DROP ALL COVERAGE**	☐ **DROP DEPENDENT** ***Must complete Section 4A***	☐ **ADD DEPENDENT** ***Must complete Sections 4A, 4B, 5, & 6***

Section 4A: Dependent Information (Attach additional sheet of paper, if necessary. Sign and date it.)

	First Name, M.I., Last Name	Social Security No.	Birthdate (mm/dd/yyyy)	Gender	Relationship
☐ **ADD** ☐ **DROP**				☐ M ☐ F	SPOUSE
☐ **ADD** ☐ **DROP**				☐ M ☐ F	CHILD
☐ **ADD** ☐ **DROP**				☐ M ☐ F	CHILD
☐ **ADD** ☐ **DROP**				☐ M ☐ F	CHILD
☐ **ADD** ☐ **DROP**				☐ M ☐ F	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? ☐ YES ☐ 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

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

☐ 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.

☐ **Employee:** I do not wish to apply for any coverage. I understand that if I decide to apply at a later time, coverage may not be available until the next open enrollment.

☐ **Retiree:** I understand that if I drop coverage, I will **NOT** be eligible to apply again.

Section 8: Signature

Employee/Retiree 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 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.