



Section A: Current Information

Form with fields: Group Name, Group #, Division #, Employee Name, Social Security #, Effective Date of Coverage, Date of Event

Section B: Coverage Change Information

Form with fields: Reason for Change (Adoption, Birth, Death, Divorce, etc.), Change Request Type (New Name, New Address, etc.), Plan Coverage Type Requested, Employee Plan Choices, Physician Plan Choices, Coverage Level Requested, Primary Care Physician Name, Existing Patient status

Section C: Dependent Information - Attach separate sheet if additional space is needed for dependent information, sign & date.

Table with columns: Last Name, First Name, M.I., Social Security Number, Birth Date, Relation to You (Spouse, Child, Other), Sex (M or F), Check if Disabled

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 D: Other Health Insurance Information This section must be completed for claims processing and Prior Coverage Information.

Form with text: 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? No Yes BCBSF Contract#

Section E: Change Authorization

Form with fields: Employee Signature, Date, Employer Signature, Date