



Life, Accident & Disability Income Insurance By:
Florida Combined Life
Independent Licensee of the Blue Cross and Blue Shield Association

Universal Individual Application For Group Insurance/Membership

Please PRINT or TYPE Clearly in Blue or Black Ink Only. Blue Shaded Areas to be Completed by Group Administrator.

1. Type of Product <input type="checkbox"/> BlueCare <input type="checkbox"/> Traditional <input type="checkbox"/> BlueChoice <input type="checkbox"/> Other <input type="checkbox"/> BlueOptions	2. Product Plan Option Number	3. Type of Coverage <input type="checkbox"/> Health/Life <input type="checkbox"/> COBRA <input type="checkbox"/> Health Only <input type="checkbox"/> Other <input type="checkbox"/> Life Only	4. Group Number	5. Division Number	6. Package Number	7. Effective Date	8. Class Number
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9. REFUSAL OF ANY / ALL COVERAGE / MEMBERSHIP
 Read and sign below only if you wish to refuse **Any** or **All** coverage offered by Blue Cross and Blue Shield of Florida, Inc. ("BCBSF"), Health Options, Inc. ("HOI") and Florida Combined Life Insurance Company, Inc. ("FCL") or other affiliated carrier. I do not wish to apply for coverage/ membership. I understand that, if I decide to apply at a later time, that coverage/membership may not be available until the next open enrollment period.

BlueCare BlueChoice BlueOptions Traditional FCL Coverage Dental Assistance Plan
 Other _____

10. Term Life <input type="checkbox"/> YES <input type="checkbox"/> NO	11. AD & D <input type="checkbox"/> YES <input type="checkbox"/> NO	12. Supplemental Term Life <input type="checkbox"/> YES <input type="checkbox"/> NO Amt. \$ _____	13. Supplemental AD & D <input type="checkbox"/> YES <input type="checkbox"/> NO Amt. \$ _____	14. STD Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO Amt. \$ _____	15. LTD Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO Amt. \$ _____	16. Dependent Life <input type="checkbox"/> YES <input type="checkbox"/> NO Amt. \$ _____	17. Other Benefits <input type="checkbox"/> YES <input type="checkbox"/> NO Amt. \$ _____
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18. Full-Time Hire Date Month _____ Day _____ Year _____
19. Name of Group Employer _____
20. Occupation _____
21. Applicant's Social Security Number _____

22. Last Name _____ **First Name** _____ **M.I.** _____
23. Birth Date Month _____ Day _____ Year _____
24. Street Address _____

25. City _____ **County** _____
26. State _____ **Zip** _____
27. Home Phone Number () _____

28. Employee Number _____ **29. Location Number** _____
30. Annual Gross Salary \$ _____
31. Paid Hourly Salary
32. E-Mail Address _____
33. Business Phone Number () _____

34. Marital Status
 Single Divorced Legally Separated
 Married Widowed
35. Type of Health Coverage
 Employee Employee/Family Employee/Spouse* Employee/Child(ren)*
 *Only available where offered
36. Type of Dental Coverage
 Employee Employee/Family Employee/Spouse* Employee/Child(ren)*
 *Only available where offered
37. Sex
 M F

38. 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.

39. Applicant's Primary Care Physician(s)
 For BlueCare, Care Manager & Elect Care Coverage/Membership. (Last Name, First Name) _____
Primary Care Physician Number _____
Current Patient Yes No

IMPORTANT: If the BlueCare, Care Manager or Elect Care Product was selected, a Primary Care Physician must be selected from the Health Options, Inc. provider directory for each proposed member BEFORE coverage can become effective. (See Boxes 39 & 40)

Relation To You	First Name and Middle Initial Last Name (if not the same)	Social Security Number	Sex	Birth Date Mo. Day Yr.	Check if:				40. Dependents Primary Care Physician(s) For BlueCare, Care Manager & Elect Care Coverage/Membership. (Last Name, First Name)	Primary Care Physician Number	Current Patient Yes No
					Disabled	Supported by you &	Living with you	Full-Time/Part-Time Student			
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	<input type="checkbox"/> Yes <input type="checkbox"/> No			
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	<input type="checkbox"/> Yes <input type="checkbox"/> No			
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	<input type="checkbox"/> Yes <input type="checkbox"/> No			
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	<input type="checkbox"/> Yes <input type="checkbox"/> No			

41. If you or your dependents currently have coverage, or had any coverage within the past 63 days which this coverage replaces, please fill out and attach a Prior/Concurrent Coverage Affidavit form (Form 10250) or attach a Certificate of Creditable Coverage.

42. Primary Life Insurance Beneficiary (s)	Last Name _____ Last Name _____	First _____ First _____	M.I. _____ M.I. _____	Relation to You _____ Relation to You _____	%Share _____ %Share _____
43. Contingent Life Insurance Beneficiary (s)	Last Name _____ Last Name _____	First _____ First _____	M.I. _____ M.I. _____	Relation to You _____ Relation to You _____	%Share _____ %Share _____

Other Carrier Liability Information – THIS SECTION MUST BE COMPLETED

44. On the day your 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.

45. Health	46. <input type="checkbox"/> Additional Health OR <input type="checkbox"/> Dental	47. 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 _____ <input type="checkbox"/> Active <input type="checkbox"/> Retired	Employment Status _____ Name of Employer _____ <input type="checkbox"/> Active <input type="checkbox"/> Retired	Entitlement Reason _____ <input type="checkbox"/> Age 65 or older	Entitlement Reason _____ <input type="checkbox"/> Age 65 or older
Policy# _____ Effective Date _____ Type of Coverage _____ <input type="checkbox"/> Single <input type="checkbox"/> Family	Policy# _____ Effective Date _____ Type of Coverage _____ <input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> End Stage Renal Disease
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 _____

48. Acceptance of Any Coverage / Membership
 I have read and understand the Acceptance of Any Coverage / Membership on the reverse side of this form.

 Signature of Applicant / Employee Date



Acceptance of Any Coverage/Membership - Read Before Signing on the Front of this Form.

I hereby apply for the coverage/membership selected on the front side of this form. My employer has selected the coverage/membership through Blue Cross Blue Shield of Florida, Inc. ("BCBSF"), Health Options, Inc. ("HOI") and/or Florida Combined Life Insurance Company, Inc. ("FCL") (or other affiliated carrier). 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, HOI and/or FCL (or any other affiliated carrier) accepts this application and assigns an effective date; and 4. if I am not actively at work on my proposed coverage effective date of any FCL coverage, my effective date for such coverage may be deferred; it may be deferred until the date I return to active work.

I AGREE that any controversy or dispute between Health Options, Inc. and myself or my dependents shall be subject to the disputes resolution and grievance procedures set forth in the HOI Complaint and Grievance Process Section of the Health Options, Inc. subscriber agreements.

I understand that my employer is not an agent of BCBSF, HOI and/or FCL (or other affiliated carrier). I also understand that my employer is responsible for notifying all employees of all: 1. effective dates; 2. termination dates; 3. any conversion, COBRA or ERISA rights or responsibilities; and 4. other matters pertaining to coverage/membership under the group contract.

I authorize persons or entities that have any medical or other records or knowledge of me or my eligible dependents to release such information to BCBSF, HOI and/or FCL (or other affiliated carrier or reinsurer). These include any: 1. licensed physician; 2. medical practitioner; 3. hospital; 4. clinic or other medical or medically related provider; 5. insurer; 6. employer; or 7. other organization, institution, or person. This information may also be released to any affiliated or reinsurance carrier. I authorize BCBSF, FCL 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. This information includes specific medical information on me or on my dependents. These releases specifically include, but are not limited to, authorization to release: 1. any and all medical records; and 2. information about, associated with, or with reference to certain conditions. I authorize BCBSF, HOI or FCL to exchange benefit information with any: 1. insurance company; 2. organization; or 3. individual. This exchange is to determine if the coordination of benefits applies for me and my dependents.

When an overpayment is made, I authorize BCBSF, HOI and/or FCL to recover the excess from any person or entity that received it.

I acknowledge that BCBSF, HOI and/or FCL (or other affiliated carrier) coverage/membership is contingent upon the complete, accurate disclosure of the information requested on this form. I acknowledge that, if I apply for BCBSF, HOI and/or FCL (or other affiliated carrier) coverage/membership later, coverage/membership may not be available until the next annual open enrollment. Also, I may be required to furnish evidence of insurability.

I represent that the statements on this application are true and complete. I understand and agree that any misstatements 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. I understand that this application is hereby made a part of the group contract.

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.