Florida Blue
In the pursuit of health®

Change Application – Individual Direct Pay

Please Complete Part 1 for ALL Requests

I hereby request the following changes(s) to my Florida Blue health insurance policy.

- ☐ CHANGE POLICY HOLDER
- ☐ ADD NEWBORN(S), ADOPTED CHILDREN,OR FOSTER CHILDREN (A new Medical Application must be completed to add other dependents)
- ☐ DELETE DEPENDENT(S) (Divorced, Deceased, Over age 65, Other)
- ☐ NAME CHANGE
- ☐ CHANGE PAYMENT MODE

CHANGE TYPE POLICY:

- ☐ FAMILY TO SINGLE
- ☐ SINGLE TO FAMILY

Part 1 (Required)

CURRENT POLICY HOLDER'S NAME (Last, First, Middle Initial)				POLICY NUMBER	
STREET ADDRESS (Include Apartment #)				COUNTY	
CITY				STATE	ZIP +4
(AREA CODE) TELEPHONE NUMBER	DATE OF BIRTH (Month/Day/Year)	AGE	SEX ☐ MALE ☐ FEMALE		

Part 2

LIST NEWBORN(S), ADOPTED OR FOSTER CHILDREN TO BE ADDED ***(Attach proof of adoption or placement with the intent to adopt and/or court decree for foster children.)***

FIRST NAME AND MIDDLE INITIAL (Include last name if different from policy holder)	SOCIAL SECURITY # (N/A for newborns.)	DATE OF BIRTH (Month/Day/Year)	AGE	RELATION TO ME	ZIP
1.					
2.					

Part 3

LIST ANY MEMBER(S) TO BE DELETED FROM COVERAGE ***(If the member is eligible for continuous coverage, please complete a PPO-Eligible Dependent Application.)***

FIRST NAME AND MIDDLE INITIAL (Include last name if different from policy holder)	SOCIAL SECURITY #	DATE OF BIRTH (Month/Day/Year)	AGE	RELATION TO ME	ZIP
1.					
2.					

INDICATE REASON AND DATE: (DATE IS REQUIRED)

☐ DIVORCE ____________ Month/Day/Year

☐ DECEASED ____________ Month/Day/Year

☐ AGE 65 OR OVER ____________ Month/Day/Year *(Birthdate)*

☐ OTHER *(please explain)* ____________ Month/Day/Year

Part 4

NAME CHANGE ***(If legal or divorce, please attach supporting documentation.)***

CHANGE NAME FROM: ______________________ TO: ______________________

INDICATE REASON FOR NAME CHANGE: ☐ MARRIAGE ☐ LEGAL ☐ DIVORCE

Part 5

PLEASE CHECK THE FREQUENCY OF PREMIUM PAYMENTS YOU PREFER (CHECK ONE ONLY)

☐ Monthly ☐ Bi-Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ Automatic Payment Option (Please complete separate authorization form.)

SIGNATURE (Reqd)

I hereby request the changes indicated above to my Florida Blue health insurance policy. I understand and agree that the changes will not be effective until the Change Application is accepted and the initial rate is paid. I declare that all statements made are true and complete. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurer, or files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

X ______________________________
POLICY HOLDER'S SIGNATURE (REQUIRED)

____
DATE OF CHANGE APPLICATION

The Summary of Benefits and Coverage (SBC) is available at floridablue.com. A paper copy is also available, by calling 1-800-352-2583. TTY/TDD dial 1-800-955-8771.

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