Florida Blue HMO

Change Application – Individual HMO Direct Pay

Please Complete Part 1 for ALL Requests

I hereby request the following changes(s) to my Florida Blue Health Options product.

- ☐ 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 CHILDREN 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	PRIMARY CARE PHYSICIAN	BCBSF PROVIDER ID#	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 HMO-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 HMO health coverage. 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.

72843 0912 Florida Blue HMO is the trade name of Health Options, an HMO subsidiary of Florida Blue. These companies are independent licensees of the Blue Cross and Blue Shield Association.