Important Notifications/Frequently Asked Questions

Applicant:

Where do I send my paper application?

Please return your completed application to the agent who assisted you with enrollment to ensure your application is processed correctly.

How can I obtain status on my paper application submission?

Please contact Member Services at 1-855-805-8175.

Agents:

Where do I send my paper application?

Once you have reviewed and signed the application, please send the final completed application to:

Florida Blue

P.O. Box 45074

Jacksonville, FL 32232

How can I obtain status on my paper application submission?

Please contact the Agent Service Center at 1-800-267-3156

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

INDIVIDUAL APPLICATION FOR HEALTH INSURANCE

P. O. Box 45074 • Jacksonville, FL 32232

Div. Code	Effective Date	DO NOT WRITE IN SHADED AREA – FOR HOME OFFICE USE ONLY

MEMBER #	SMOKER	RATING – CODE	COMMENTS

SUBMITTED BY:

Writing Agent Name (please print) _____

Writing Agent Signature _____

Agency Name _____

Agency Address _____

Agency Telephone Number _____

Agency Code/Agent Code _____ Keycode _____

ENROLLMENT INFORMATION

I AM APPLYING FOR: Select one of the options below:

❍ Open Enrollment: (Skip to Part I Enrollment Information.)

❍ Special Enrollment: (Florida Blue must be notified by the required timeframe stated below for the applicable Qualifying Event to be eligible for Special Enrollment. Special Enrollment only applies to those individuals who experience at least one of the Qualifying Events noted below: (complete Special Enrollment Period section below)

IMPORTANT: You must enroll within 60 days of your qualifying event to be eligible for Special Enrollment unless otherwise noted.

SPECIAL ENROLLMENT PERIOD

Please check your Qualifying Event and include the date of the event

❍ Birth, adoption, placement for adoption, court order or placement for foster care

❍ Newly married or newly eligible domestic partner

❍ Became legally present in the United States. Insert citizenship date _____

❍ Recent or approaching loss of minimum essential coverage **IMPORTANT:** Loss of minimum essential coverage does not include voluntary termination or loss due to (1) failure to pay premiums on a timely basis, or (2) fraud or misrepresentation.

❍ Gained access to new health insurance coverage as a result of a permanent move. Provide county you moved from _____
Note: You will be asked for your new address in Question 3.

❍ Currently enrolled in a non-calendar year health insurance policy and the policy year is ending within the next 90 days

❍ Experienced an error or misrepresentation during enrollment. Provide details: _____

❍ Experienced material violation of your current health insurance policy. Provide details: _____

❍ Individual's loss of eligibility for advanced premium tax credit or cost-sharing.

❍ Currently enrolled in a Florida Blue plan that was effective since at least December 31, 2013 and want to purchase a plan with the new Affordable Care Act benefits.

❍ Enrolled in a Florida Blue plan during open enrollment and now want to move to a new Florida Blue plan with a different network of providers. The new plan must be within the same metal level as the original plan. Note: You only have 60 days after the end of open enrollment to make plan changes.

❍ Death of the policyholder or dependent

❍ Legal Separation or Divorce

❍ Other (please specify): _____

Insert Date of Qualifying Event checked above: _____

By checking a qualifying event above you represent you meet the eligibility criteria for a special enrollment period and the information provided is accurate and complete. Upon request Florida Blue may request additional documentation to confirm whether you qualify for a special enrollment period.

PART I: ENROLLMENT INFORMATION

1. Product Type: ❍ BlueOptions Plan # _____ ❍ BlueSelect Plan # _____ | 2. Variation ID: ❍ P ❍ V

❍ New Business/Continuous Coverage ❍ Add-On ❍ Product Change ❍ Child Only **Note:** Please select all that apply

❍ **For Catastrophic Plans.** By checking this box, I certify that all individuals on this application are eligible to purchase and enroll in a catastrophic plan. To be eligible, each individual must be under the age of 30 or qualify for a hardship exemption from the individual shared responsibility payment. If you are applying because your current health insurance policy is being canceled, you must include a completed copy of your Health Insurance Marketplace hardship application with this application. For all other qualifying hardships Florida Blue may request additional supporting documentation.

❍ **For plans without a P or V Variation ID.** By checking this box I understand that this plan does not offer coverage for pediatric dental services. Pediatric dental coverage is available and can be purchased as a stand-alone product. I certify that if individuals under the age of 19 are enrolled in this plan they are also enrolled in an Exchange certified stand-alone pediatric dental plan. I agree to notify Florida Blue immediately if such pediatric dental coverage is terminated.

Please include the pediatric dental plan information for all individuals under the age of 19 below.

Plan Name / Number _____ Carrier _____ Effective Date _____

APPLICANT TO BE CONSIDERED FOR COVERAGE:
Home Telephone ( ) Work/Cell Telephone ( ) E-mail Address:

I agree to electronic fulfillment: ❍ Yes ❍ No

This information is optional and is for data collection only. It will not determine eligibility, rating or claim payment.
Language Preference: ❍ English ❍ Spanish ❍ Other: _____

Is anyone on the plan entitled to benefits under Medicare Part A or enrolled under Medicare Part B? ❍ Yes ❍ No
If yes, those individuals are not eligible to apply for this plan.

2. SOCIAL SECURITY NO.	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH Month Day Year

3. HOME ADDRESS (Include Apartment #, Lot # or Route #) P.O. Box should NOT be indicated	CITY

COUNTY NAME	COUNTY CODE	STATE	ZIP	DATE OF RESIDENCY IN FL Month Day Year

4. OTHER MAILING ADDRESS IF DIFFERENT THAN IN QUESTION #3: ❍ Billing Only or ❍ Correspondence & Billing
ADDRESS _____ CITY _____ STATE _____ ZIP _____

5. MARITAL STATUS: ❍ Single ❍ Married SEX OF APPLICANT: ❍ Male ❍ Female

6. IMPORTANT FIRST NAME, M.I., LAST NAME (Last Name if Different than Applicant)	SOCIAL SECURITY NUMBER	AGE	DATE OF BIRTH Mo. / Day / Yr.	RELATIONSHIP TO APPLICANT	ZIP CODE (if other than #4)
6.A. Applicant	Above		Above	Self	
6.B.				☐ Spouse ☐ Domestic Partner	
6.C.				☐ Son ☐ Daughter ☐ Other _____	
6.D.				☐ Son ☐ Daughter ☐ Other _____	
6.E.				☐ Son ☐ Daughter ☐ Other _____	
6.F.				☐ Son ☐ Daughter ☐ Other _____	

7. Has the Applicant, or Spouse/Domestic Partner, or any dependent age 18 or older used tobacco in any form (e.g., cigarettes, cigars, pipes, snuff or chewing tobacco) regularly four or more times per week on average, excluding religious or ceremonial uses, in the past six months? ❍ Yes ❍ No
If "Yes", please identify person and date of last use: _____

8.A. Will this policy replace any other hospital or medical insurance or HMO coverage, including group coverage, currently in force? ❍ Yes ❍ No
If "YES", complete Replacement of Coverage section below
B. Will this policy replace any dental insurance currently in force? ❍ Yes ❍ No

Replacement of Coverage

Company Name _____ Group Policy # _____ and/or
Street Address _____ Individual Policy # _____
City, State, Zip _____ Is this COBRA? ❍ Yes ❍ No

Please indicate the type of coverage being replaced: ❍ Major Medical; ❍ Hospital & Surgical; ❍ Hospital Indemnity; ❍ Accident Policy; ❍ Cancer Policy; ❍ Dental

What was the effective date of coverage: _____

Is this coverage expiring/terminating due to contractual cessation, limiting age, etc.? ❍Yes ❍No

If "YES", why? _____ What date? _____

If reason for replacement is other than above, please provide details: _____

_____

If not expiring/terminating, what is the date through which premiums have been paid? _____

Please list all family members covered under the insurance policy being replaced: _____

_____

If any member covered under your current policy is not enrolling with Florida Blue please advise why they are not included:

_____ _____

_____ _____

Have you had coverage with Florida Blue previously? ❍ Yes ❍ No

If "YES", please provide Policy # _____ Termination Date: _____

_____

PART II: SUPPLEMENTAL INFORMATION

1. Has the last name of any person to be covered changed in the last 5 years due to marriage, court order, etc.?.....❍Yes ❍No
   If "YES", please advise the complete former name: _____
2. A. Are all persons listed in Part I, Question #6 United States citizens? .....❍Yes ❍No
   B. If "No" to 2.A., do all persons listed in Part I, Question #6 have a resident alien card? .....❍Yes ❍No
   C. If "No" to 2.B., do all persons listed in Part I, Question #6 have a VISA? .....❍Yes ❍No

Member Name	Type of VISA	VISA Expiration Date

   D. Are all persons named in Part 1, Question 6.A & B permanent residents of the State of Florida? .....❍Yes ❍No
   E. Are the Applicant and Sales Agent related? .....❍Yes ❍No
3. Agent Remarks:_____

_____

PART III: ADDITIONAL INFORMATION

The Sales Agent thoroughly explained the following matters to me:

A. From time to time, a rate adjustment may be necessary for any given product. The premium rate for my coverage may change if I move to another rating area in Florida or my tobacco status changes and the new premium rate effective date will be based on when I provide you with a notice of my new address or a change in tobacco status. My premium rate may change on my anniversary date due to an increase in the age of Covered Persons.....❍Yes ❍No
B. BlueSelect may not be available in all areas of the state.....❍Yes ❍No
C. If applicable, applicant agrees to pay directly to providers of health care such copayments as are required by the contract under which they are enrolled.....❍Yes ❍No
D. There is no coverage for services subject to Exclusive Provider Provision(s) received outside of the EPO network in non-emergency situations.....❍Yes ❍No

Applicant's Signature: **X** _____Date: _____

PART IV: PREMIUMS AND PAYMENTS

I have read and understand the following:

A. Premium Receipt

I have personally completed this application and my agent, if applicable, has read and explained this Premium Receipt section to me.

I understand that if premium is included with this application, this premium receipt is issued on the condition that the payment is good and collectible. The deposit of my payment to the account of Florida Blue does not guarantee that a contract will be issued to me.

I understand that I will not receive any health coverage under my plan unless 1) my application is accepted by Florida Blue 2) issuance of a contract is approved by Florida Blue 3) a contract is issued and accepted by me; and 4) my premium payment is made by the effective date or due date on the invoice subject to any applicable grace period.

If this application is not accepted, I understand that I will not receive a contract and any payments made for this plan will be refunded to me.

B. Payments

I understand that I may receive a supplemental bill for the time period between the termination date of my prior coverage and the start of my new Florida Blue billing cycle.

I have read and explained this **Cash Receipt** to the applicant. I have received an application for a health insurance policy and an initial premium payment of $ _____ from _____

Signature of Agent: _____ Date: _____

I have personally completed this application for an Individual product and the Agent has read and explained this **Cash Receipt** to me.
I understand that I will not receive any coverage UNLESS my application is accepted and a policy is issued.

Applicant's Signature: X_____ Date: _____

PART V: AUTHORIZATIONS/ACKNOWLEDGEMENTS

I understand that the product I am applying for is offered by Blue Cross Blue Shield of Florida, Inc., DBA Florida Blue, an Independent Licensee of the Blue Cross and Blue Shield Association.

CANCELLATION PROVISION

I understand that Florida Blue may cancel this coverage for all Covered Persons covered by it after giving 90 days' notice, and that any unearned premiums will be returned to me. I also understand that such action will not be taken solely because of the amount of claims paid under this contract.

Applicant's Signature: **X** _____ Date: _____

PLEASE READ AND SIGN

I hereby apply for individual health care coverage for myself and eligible dependents under the Florida Blue product indicated in Part I, Question #1 of this application. I acknowledge that any coverage is contingent upon the complete and accurate disclosure of the information requested in this application. Florida Blue reserves the right to cover only those individuals that meet the eligibility requirements of the product, and this may result in Florida Blue declining me or any of my dependents.

COVERAGE DETAILS

I acknowledge that I have reviewed and understand the terms of coverage, limitations, exclusions and benefit and payment rules applicable to the product for which I am applying. I further understand that the product for which I am applying for provides no coverage for services subject to the Exclusive Provider Provisions(s) received outside of its network of EPO providers in non-emergency situations. I acknowledge that I have received descriptions of (1) the exclusive providers; (2) the exclusive provider provisions, including coinsurance and deductible levels if providers other than exclusive providers are used; (3) coverage for emergency and urgently needed care and other out-of-service area coverage; (4) limitations on referrals to restricted exclusive providers and to other providers; and (5) Florida Blue's quality assurance program and grievance procedure. I further acknowledge that I understand the restrictions of the product for which I am applying.

Authorization to Share Limited Information

If I am enrolling in a high-deductible health plan designated for use with a Health Savings Account (HSA) under Internal Revenue Service Code section 223, I understand that Florida Blue will 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.

Replacement of Insurance (if applicable):

I have read and understand the following:

According to the information you gave us in your application, you intend to lapse or terminate your existing health or dental coverage and replace it with Florida Blue Coverage.

FOR YOUR INFORMATION AND PROTECTION, YOU SHOULD BE AWARE OF AND SERIOUSLY CONSIDER, CERTAIN FACTORS WHICH MAY AFFECT THE COVERAGE AVAILABLE TO YOU UNDER YOUR NEW CONTRACT.

You may wish to secure the advice of your present health or dental benefits provider (e.g., insurer, HMO, PPO) or its agent regarding the proposed replacement of your present policy. This is not only your right, but is also in your best interest to understand all the relevant factors involved in replacing your present coverage.

You should also become familiar with the renewal provisions of the contract for which you are applying to make sure that you understand your rights regarding the periodic renewal of the contract as stated in the renewal provisions of the new contract.

So that we may coordinate your effective date, it is important that you advise your agent of any payments made on your existing health or dental coverage while this application is being considered.

If your application is approved, please note that, because the new contract for which you have applied will be issued at a later date than used for your present policy, the cost of the new contract, depending on the benefits, may be higher than what you are paying for your current policy because you may be older than you were when your present policy was issued. Also, please understand that this contract is age-rated and premiums are based on your age and or the ages of your covered dependents. Rates may be adjusted on your anniversary date due to changes in your age or ages of your covered dependents.

I understand that a contract may not be issued by Florida Blue and that I should keep existing coverage until a Florida Blue contract has, in fact, been issued to, and coverage is accepted by, me.

GUARANTEED ISSUE ACKNOWLEDGEMENT

I understand and acknowledge that I may be eligible for a Guaranteed Issue health care coverage policy ("HIPAA or Conversion coverage") in accordance with Florida Statute section 627.6487,627.6675 or 641.3921. However, I am choosing to submit an application for another product. I understand that it is in my best interest to contact an authorized Florida health insurance issuer that offers HIPAA (guaranteed issue) coverage options. To pursue the Guaranteed Issue or Conversion health care coverage option, I understand that I must complete and submit an application for that product within 63 days from the termination of my prior coverage.

New policy effective date

I have read and understand the following:

I acknowledge that coverage will not start until my application is approved by Florida Blue, a contract is issued and accepted by me, the initial premium, if required, is paid, and the statements in this application continue to be complete and true to the best of my knowledge and belief as of the effective date of this contract. No agent can make or change a contract or waive any of the rights of the company.

If my application is approved and accepted, I understand there is no coverage under the Florida Blue contract for which I am applying until the effective date approved by Florida Blue.

A. Open Enrollment

For coverage effective during the 2016 calendar year, open enrollment begins October 1, 2015 and ends January 31, 2016.
The effective date of coverage during 2016 will depend on the application date:

- For an application date on or before December 15, 2015, the effective date of coverage will be January 1, 2016;
- Between the first and fifteenth day of any subsequent month during the open enrollment period, the effective date of coverage will be the first day of the following month;
- Between the sixteenth and last day of any month between December 2015 and January 31, 2016, the effective date of coverage will be the first day of the second following month.

B. Special Enrollment

For any individual who qualifies for Special Enrollment, the effective date of coverage will be determined based on the type of special enrollment event in accordance with state and federal law.

EMPLOYER PAID PREMIUMS

I understand and agree that the contract for which I am applying is not intended by Florida Blue to be a small employer health plan, as Florida law defines that term. I further agree that the employer of any individual listed on this application will not contribute any portion of the premiums for this contract, directly or indirectly. I also agree that no employer of an individual listed on this application will facilitate the administration of coverage of the contract, as Florida law defines that term.

If my employer is submitting payments on my behalf, I understand that my employer may not provide any administrative support for the billing and/or submission of my individual premium payments, unless the payments are being submitted in accordance with the Florida Blue's list-billing agreement with my employer and Florida Statutes sec. 627.6699(4) (a) or any successor statutes.

If an employer contributes a portion of the premium for any individual listed on this application, I agree that one of the following conditions must be met: 1) the individual is a part-time employee working less than 25 hours per week and is not eligible for a group plan or, 2) the individual is an employee working under an independent contractor agreement or, 3).the individual is self-employed and has elected to purchase individual coverage or, 4) the individual is a temporary or substitute employee.

Child-only Application, if applicable

I am applying for a child-only contract. I agree that I have read and understand the following: The name of the child to be considered for coverage appears on the application as the "Applicant." I certify that all statements and answers in this application are entirely true and complete to the best of my knowledge and belief and deemed to be representations and not warranties. As parent or guardian of the applicant, I will be responsible for paying coverage. If I am a legal guardian, court-ordered guardianship papers are required and I will be notified of the appropriate submission procedures.

Consent to Receive Electronic Communications

We may periodically send you information regarding our administration of your health insurance. This information may include Member Health Statements, a Summary of Benefits and Coverage and our Notice of Privacy Practices. We understand that some of our members desire to either receive or access this information electronically. We offer these members the opportunity to have us provide them with this information using some type of electronic technology that we may choose (e.g., we may choose to provide you with electronic access to this information through your online Member account, sending you this information as a file attached to an email or sending you this information via traditional mail by including some other type of enclosed electronic medium, such as a USB flash drive or other data storage device). There are potential problems that can occur with certain electronic communications that are beyond our control. For example, even though we will use reasonable means to protect the security of email communications we cannot guarantee the confidentiality of this information when it is transmitted this way. Emails can be intercepted, altered, forwarded or used without authorization or detection. Please consider the risks associated with electronic communications before you sign the consent below.

By agreeing to electronic fulfillment in part I, you agree to receive future communications electronically, including but are not limited to, information pertaining to your coverage or benefits, such as the Member contract, Explanation of Benefits, Member Health Statements, Summary of Benefits and Coverage, and the Notice of Privacy Practices. We may use different technologies to provide you with electronic communications, such as through an electronic medium, such as a USB flash drive or other data storage device. As a condition of this Consent you agree to provide a valid e-mail address and keep it up to date. You understand that failing to update your e-mail address may result in a delay or failure of notification of important information. You may change this communications preference or request a free paper copy of any electronic communication at any time by calling us or, for certain communications, logging on to your online Member account. We reserve the right to cease using electronic communications or impose additional use restrictions at any time and in our sole discretion. This Consent to our use of electronic communications includes your agreement to all terms in this paragraph.

ENROLLMENT PROVISIONS

I have read this application carefully and I represent that the statements/answers contained within are entirely true and complete to the best of my knowledge and belief.

If I enrolled in my current Qualified Health Plan on the Federal Marketplace and want to switch to an Off-Marketplace plan, I understand that I am responsible for canceling from my current health plan on the Marketplace (www.healthcare.gov).

If I currently have a Florida Blue or Florida Blue HMO plan not purchased on the Federal Marketplace and want to purchase a different Florida Blue or Florida Blue HMO plan Off-Marketplace, I understand that Florida Blue or Florida Blue HMO will automatically cancel all enrolled members from my current plan as of the last day of the month prior to the coverage effective date of my new plan. I also understand that my newly selected plan will replace my current plan coverage as of my new plan's effective date and that I will not be able to switch back to any of my previously purchased plans at that time or at a later date.

I understand and acknowledge that if I am applying for coverage due to a special enrollment period, I meet the eligibility criteria for a special enrollment period selected and the information provided is accurate and complete. I understand that I may be required to provide additional documentation to confirm eligibility for the special enrollment period upon request from Florida Blue.

Summary of Benefits and Coverage (SBC)

The Summary of Benefits and Coverage (SBC) is available in English on our website at: FloridaBlue.com/sbc. If you are unable to locate your SBC on the website or you wish to have an SBC sent to you, free of charge, call: 1-800-352-2583. TTY/TDD dial 1-800-955-8770.

I have read this application carefully and I represent that the statements and answers I am submitting on this application are entirely true and complete to the best of my knowledge and belief. No information has been withheld or omitted. **I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.** I understand that if I am accepted for coverage, I will have ten (10) days after my policy is received by me to review it and submit any information that is incorrect or incomplete.

Applicant's Signature: **X**_____ Date: _____

Parent / Guardian Name: _____ Relationship: _____

Spouse / Domestic Partner's Signature: **X** _____ Date: _____

Signature for any Dependent 18 and over: **X** _____ Date: _____

FOR AGENT USE ONLY:

Agent Certification: I hereby certify that I have seen and personally asked the applicant all questions set forth above and that I have accurately recorded answers supplied by the applicant. I further certify that I have explained exclusions and limitations of this plan. I will provide a copy of the final signed application to the applicant for their records. I also verified that no person named in Part 1, Question #6 is now eligible or to become eligible in the next six months for a group type health plan.

I certify that I have reviewed the applicant's eligibility criteria for a special enrollment period and verified that the information provided is accurate and complete. I will retain a copy of the documentation in accordance with the record retention requirements of applicable law and regulation, and understand that I will be required to forward this documentation to Florida Blue upon request.

Agent Name: _____ Agent's License No.: _____
(Please Print)

Agent Signature: _____Date: _____

Telemarketing Sales Agent Certification: I hereby certify that I personally asked the applicant during a telephone call all questions set forth above and that I have accurately recorded answers supplied by the applicant. I further certify that I have explained exclusions and limitations of the plan selected. I will provide a copy of the final signed application to the applicant for their records. I also verified that no person named in Part 1, Question #6 is now eligible or to become eligible in the next six months for a group type health plan.

Sales Agent Name: _____ Agent's License No.: _____
(Please Print)

Sales Agent Signature: _____Date: _____Time: _____