BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

HEALTH INSURANCE ENROLLMENT FORM

1. Type of Health Insurance Product		
☐ Blue Options 05770	☐ Blue Options 05902	☐ HSA 128/129 (Blue Care)
☐ Blue Options 03160/03161 HSA	☐ HMO (Blue Care 60)	
☐ Blue Options 03900	☐ HMO (Blue Care 53)	

FOR LANDRUM USE ONLY
Effective Date

Worksite Employer: _____ Full Time Hire Date: _____

PLEASE PRINT CAREFULLY

2. Last Name	First Name	M.I.	3. Applicant's SSN	4. Birthdate

5. Street Address	City	State	County	Zip

6. Work Phone Number	7. Home Phone Number	8. Marital Status
		☐ Single ☐ Divorced ☐ Married ☐ Widow

9. Type of Coverage		10. Sex
☐ Employee	☐ Employee + Child(ren)	☐ Male
☐ Employee + Spouse	☐ Employee + Family	☐ Female

11. LIST ELIGIBLE FAMILY MEMBERS TO BE COVERED. Use additional sheet if necessary. A copy of the court order must be attached for dependents if court-ordered custody or guardianship.

IMPORTANT: If HMO was selected, a Primary Care Physician (PCP) must be selected from the Provider directory for each proposed member.

Related to You	First Name and Middle Initial Last name (if not the same)	Social Security Number	Dependent Birthdate MM/DD/YYYY	Primary Care Physician	PCP Number
Self					
Relationship: _____					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					

12. IMPORTANT INFORMATION REGARDING YOUR NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment because of other health coverage, you may be able (in the future) to enroll in our health plan provided you request within 30 days after the other coverage ends. If you have a new dependent as a result of marriage, birth, or adoption, you may enroll your dependent provided you submit the appropriate form to Landrum Professional within 30 days after the life-changing event. The effective date of coverage would be the date of the life-changing event. You will not be entitled to special enrollment if loss of eligibility for coverage is the result of termination of coverage for failure to pay premiums on a timely basis or for cause. Voluntary termination of coverage does not constitute loss of eligibility of coverage. Loss of coverage is defined as loss as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment or the discontinuance of any contributions toward the health coverage plan by the employer. If you decline enrollment in Landrum Professional's group plan for you and/or your dependents, neither will be eligible to enroll until open enrollment (MAY) once a year, unless these special enrollment conditions are met.

☐ I hereby certify that I am **declining** enrollment in Landrum Professional's group health plan for ☐ myself and/or ☐ my dependents.
I (or they) currently have other health insurance coverage - **attach proof of coverage;** or

☐ I hereby certify that I am **declining** enrollment in Landrum Professional's group health plan for ☐ myself and/or ☐ my dependents.
I (or they) do not currently have health insurance coverage

By enrolling in the Florida Blue plan, you will also have access to Teladoc benefits (see summary for additional information). Landrum will provide Teladoc with your enrollment information. By signing below, you are authorizing the secure transfer of your information to Teladoc.

☐ I hereby certify that I am **accepting** enrollment in Landrum Professional's group health plan for ☐ myself and/or ☐ my dependents.

13. Signature

_____ _____
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 and 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 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 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, including binding arbitration, set forth in 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 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 also authorize BCBSF, HOI and/or FCL, at its sole discretion, to release claims information to: 1. other insurers; 2. my employer, upon request; or 3. my employer's designee, upon request. This claims 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. These conditions include: 1. a positive test result for HIV infection; 2. ARC; 3. AIDS; 4. alcohol or drug dependency; and 5. mental and nervous disorders.

I authorize BCBSF, HOI and/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 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.**