BluegrassFamily Health

Mail or Fax to - Attn:Eligibility
651 Perimeter Drive, Ste 300
Lexington, KY 40517

Phone (859) 269-4475
Fax (859) 335-3721

ELECTION/CHANGE FORM

GROUP SIZE 2-50

To be completed by employer	
Group #	Sub Group #
Group Name	
Hire Date	
Effective Date of Enrollment/Change	

Social Security No./Member No.	Employee's Last Name	First Name, MI	Gender	Date of Birth (MM/DD/YY)

Street Address	City	State	ZIP	County

Home Phone	Work Phone	Marital Status
		☐ Single ☐ Married ☐ Divorced ☐ Widowed

Type of Contract	Retired	Disabled	E-Mail Address
☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family	☐ Yes ☐ No	☐ Yes ☐ No	

☐ **ENROLL**
- ☐ Open Enrollment
- ☐ New Hire ☐ Rehire
- ☐ Loss of other coverage
  (Attach supporting documentation)

☐ COBRA/ Continuation
original start date: _____
number of months eligible (circle one)
18 29 36

☐ **CANCEL**
- ☐ Open Enrollment
- ☐ Termination of Employment
- ☐ Qualifying Event
- ☐ Term COBRA
- ☐ Other:_____
  _____

☐ **CHANGE**

Add Dependents(s)
- ☐ Open Enrollment
- ☐ Newborn
- ☐ Marriage
- ☐ Loss of other coverage
- ☐ Adoption
- ___ Other:_____

Drop Dependent(s)
- ☐ Open Enrollment
- ☐ Divorce
- ☐ Obtained other coverage
- ☐ Age Limit Exceeded
- ☐ Other:_____
  _____

General
- ☐ Name
- ☐ Address
- ☐ Telephone
- ☐ Other:_____
  _____

Persons to be Covered – List your spouse and/or dependents to be covered. Use separate form for additional dependents. If dependent coverage is waived, a waiver form must be attached for dependent(s).

FOR DEPENDENTS 19 AND OVER, PLEASE PROVIDE PROOF OF FULL TIME STUDENT STATUS.

Add (A)	Drop (D)	Relationship of Eligible Dependents	Full Name (Last, First, MI)	Date of Birth MM/DD/YY	Gender (M) (F)	Social Security No./Member No.
A	D	Spouse				
A	D	Child 1				
A	D	Child 2				
A	D	Child 3				

Prior Coverage (This section must be completed)

Have you or any dependents been covered by another health insurance plan at any time during the last 12 months? ☐ Yes ☐ No

a. Name of Insured_____ Name of Prior Employer Providing Coverage_____

b. Type of Contract: ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

c. Insurance Company Name_____ Effective Date_____ Termination Date_____

Other Health Coverage (This section must be completed)

Is your spouse employed? ☐ Yes ☐ No Employer_____

Will you or any other family member be covered through another health insurance plan? ☐ Yes ☐ No

If YES, please list names of covered individuals. _____

Insurance Company Name_____ Policy Number _____ Effective Date _____ Phone Number _____

Does this include a prescription benefit? ☐ Yes ☐ No

Terms and Conditions

A. I understand that I am responsible for promptly reporting to my employer any changes in my marital status, my number of eligible dependents or change in my residence.

B. I hereby authorize any hospital, physician, surgeon, or pharmacist to release any information requested by Bluegrass Family Health Inc. with respect to any claim of the delivery of medical care on behalf of myself or a covered dependent. A photocopy of this authorization will serve the same as the original. This authorization is not he same as a HIPAA Authorization.

C. I agree that any medical benefits payable on my behalf under my employer's Group Medical Benefits Plan may be paid directly to the provider of care.

D. I understand and agree that no benefits shall take effect until this enrollment/change form is **approved** by Bluegrass Family Health Inc. Upon acceptance, Bluegrass Family Health Inc. shall as soon as possible, issue an identification card(s) to me.

E. I authorize my employer to make the necessary deductions from my pay or any disability or retirement annuity benefits to which I may be entitled under any group plan sponsored by my employer while I am enrolled in Bluegrass Family Health Inc. until this authorization is revoked by me in writing.

F. I understand that I must be actively at work on the effective date of coverage or the effective date will be on the date I return to work, unless my absence is due to a medical condition.

G. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company, Penalties include imprisonment, fines and denial or insurance benefits. Ky. Rev. Stat. § 304.47-020; Ind. Code §35-43-5-3.4; Tenn. Code § 56-53-1-2 and 103.

Employee Signature_____Date_____ Rev. 06/07