

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 51+

To be completed by employer	
Group #	Sub Group #
Group Name	
Hire Date	Effective Date
Plan Option	

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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		

Type of Contract <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family	Retired <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	E-Mail Address
---	---	--	----------------

<input type="checkbox"/> <b>ENROLL</b> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Loss of other coverage <small>(Attach supporting documentation)</small> <input type="checkbox"/> COBRA/ Continuation original start date: _____ number of months eligible (circle one) 18    29    36	<input type="checkbox"/> <b>CANCEL</b> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Qualifying Event <input type="checkbox"/> Term COBRA <input type="checkbox"/> Other: _____	<input type="checkbox"/> <b>CHANGE</b> <b>Add Dependents(s)</b> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Newborn <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of other coverage <input type="checkbox"/> Adoption ___ Other: _____	<b>Drop Dependent(s)</b> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Divorce <input type="checkbox"/> Obtained other coverage <input type="checkbox"/> Age Limit Exceeded <input type="checkbox"/> Other: _____	<b>General</b> <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Telephone <input type="checkbox"/> 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			

**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 the 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 of 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