

Enrollment/Change Form
Use this form to Enroll, Change, or Terminate (please print in black or blue ink)

651 Perimeter Drive, Suite 300, Lexington, KY 40517
 Phone: 800-787-2680 Fax: 859-335-3721

1 ENROLLEE INFORMATION (To be completed by Enrollee)						2 EMPLOYER Complete this Section			
Social Security / Member Number		Last Name		First Name, MI		Gender <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth (MM/DD/YY)	
Mailing Address			City		State	Zip	County		
Home Phone		Work Phone		Email Address			Retired <input type="checkbox"/> Yes <input type="checkbox"/> No		
Type of Contract <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family				Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		
						Group Number (include any subgroup)			
						Company Name			
						Hire Date		Effective Date	
						Plan Option		Rider	

3 ENROLL			4 TYPE OF CHANGE				5 TERMINATION					
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Loss of other coverage*			Add Dependent(s) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Newborn* <input type="checkbox"/> Marriage* <input type="checkbox"/> Adoption* <input type="checkbox"/> Loss of other coverage* <input type="checkbox"/> Other _____				Drop Dependent(s) <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 _____			General <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Telephone <input type="checkbox"/> Other _____		
<input type="checkbox"/> COBRA/Continuation original start date: _____ Number of months eligible for COBRA <input type="checkbox"/> 18 <input type="checkbox"/> 29 <input type="checkbox"/> 36			*Supporting Documentation Required				<input type="checkbox"/> Open Enrollment <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Qualifying Event <input type="checkbox"/> Term COBRA/Continuation <input type="checkbox"/> Anticipation of Divorce <input type="checkbox"/> Other _____					
*Supporting Documentation Required			*Supporting Documentation Required				*Supporting Documentation Required					

6 DEPENDENT INFORMATION – List dependents applying for coverage						
Add (A) Drop (D)	Relationship of Eligible Dependents	Full Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Gender (Check One)	Social Security Number	
<input type="checkbox"/> A <input type="checkbox"/> D	Spouse			<input type="checkbox"/> M <input type="checkbox"/> F		
<input type="checkbox"/> A <input type="checkbox"/> D	Child 1			<input type="checkbox"/> M <input type="checkbox"/> F		
<input type="checkbox"/> A <input type="checkbox"/> D	Child 2			<input type="checkbox"/> M <input type="checkbox"/> F		
<input type="checkbox"/> A <input type="checkbox"/> D	Child 3			<input type="checkbox"/> M <input type="checkbox"/> F		

Use a separate form for additional Dependents. For Dependents Age 19 and over proof of full-time student status is required (does not apply to Tennessee domicile groups).

7 PRIOR COVERAGE (This section must be completed)	8 OTHER HEALTH 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? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Name of Insured _____ Name of Prior Employer Providing Coverage _____ b. Type of Contract: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family c. Insurance Company Name _____ Effective Date _____ Termination Date _____	Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Employer _____ On the day your coverage begins, list family members, including yourself, who will be covered by Bluegrass Family Health and any other health coverage including Medicare or retiree benefits _____ _____ Insurance Company Name _____ Policy Number _____ Effective Date _____ Does this include a prescription benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No

9 TERMS AND CONDITIONS
<ul style="list-style-type: none"> 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. I hereby authorize any hospital, physician, surgeon, or pharmacist to release any information requested by Bluegrass Family Health, Inc. (BFH) 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. 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. I understand and agree that no benefits shall take effect until this enrollment/change form is approved by BFH. Upon such acceptance, BFH shall as soon as possible, issue an identification card(s) to me. 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 BFH until this authorization is revoked by me in writing. 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. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. (TN) TCA§56-53-111, (IN) IC§35-43-5-3.5 Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. KRS§304.47-030

Employee Name (please print) _____

Employee Signature _____

Date _____