



Section A: Current Information

Group Name: Group #: Division #: Package #: Employee Name: (Last, First Name, M.I.) Social Security #: Effective Date of Coverage: Date of Event:

Section B: Coverage Change Information

Reason for Change: Adoption, Death, Leave of Absence/Layoff, Moved from Service Area, Open Enrollment, Section 125, Marriage, Birth, Over-Aged Dependent, Terminate Employment, Return of Alternate Insurance, Loss of Coverage, Divorce, Location, Employee #, Other, New Name, New Address, New Physician Name/ID, New Phone #

Plan Coverage Type Requested: Add Health, Delete Health, Change Plan: Indicate Plan #

Coverage Level Requested: Employee, *Employee & Spouse, *Employee & One Dependent, *Employee & Children, Family

Dependent Change, FSA Change, Other Change

Section C: Flexible Spending Account (FSA) Changes

Add Health Care FSA, Add Dependent Care FSA, I wish to Terminate and/or Stop Pay my FSA Health Care Program with a Final Payroll Deduction Date of: I wish to Change the Annualized Amount of my Health Care FSA to: \$

Section D: Dependent Information Attach separate sheet, if additional space is needed, with dependent information, sign & date.

Table with columns: (A) Add, (D) Delete, (C) Change, Last Name, Social Security Number, Birth Date, Relation to You, Sex, Check if Disabled, Physician Name/ID, Existing Patient, Dependent, Ethnicity

* If you indicated "O" in "Relation to You" above for any dependents, please explain here:

Section E: Other Health Insurance Information This section must be completed for claims processing and Prior Coverage Information

In addition to this policy, do you or your dependents have any other insurance coverage (including BCBSF plans) that will be in effect after this coverage begins? Yes No BCBSF Contract # Medicare # Pharmacy/Medicare D # Complete the following only if this is the first time you or your dependents: (1) are enrolling for health insurance with this employer; (2) currently have health coverage; and/or (3) have any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable Coverage. Prior Health Carrier Name: Contract #: Effective Date: Prior Employee Hire Date: Cancel Date: List names of all family members that were covered, including yourself:

Section F: Change Authorization and/or FSA Participation

I have read, understand, and agree to the Change Authorization and/or Participation in the FSA Program Terms on the back of this form. 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.

Employee Signature: Date: Employer Signature: Date: