Bluegrass Family 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	Email Address
☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family	☐ Yes ☐ No	☐ Yes ☐ No	

☐ ENROLL

___Open Enrollment
___New Hire
___Rehire
*___Loss of other coverage
___COBRA/Continuation
original start date:________________
number of months eligible (circle one)
18 29 36

*Please attach supporting documentation

☐ CANCEL

___Open Enrollment
___Termination of Employment
*___Qualifying Event
___Term COBRA/Continuation
___Other:________________________
____

☐ CHANGE

Add Dependent(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 eligible dependents to be covered. Use separate form for additional dependents.
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 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 such 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.

Employee Signature______________________________ Date______________________

Rev. 10/03