

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 51+

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 Employee Employee/Spouse Employee/Children Family Retired Yes No Disabled Yes No

Email Address _____

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

ENROLL
 Open Enrollment
 New Hire
 Rehire
 * Loss of other coverage
 COBRA
 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 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: _____

*Please attach supporting documentation
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			
A	D	Child 4			

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 _____

- 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 _____