Enrollment/Change Form

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

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

1 ENROLLEE INFORMATION (To be completed by Enrollee)

Social Security / Member Number	Last Name	First Name, MI	Gender ☐ M ☐ F	Date of Birth (MM/DD/YY)

Mailing Address	City	State	Zip	County

Home Phone	Work Phone	Email Address	Retired ☐ Yes ☐ No

Type of Contract ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Disabled ☐ Yes ☐ No

2 EMPLOYER Complete this Section

Group Number (include any subgroup)

Company Name

Hire Date | Effective Date

Plan Option | **Rider**

3 ENROLL

☐ Open Enrollment
☐ New Hire
☐ Rehire
☐ Loss of other coverage*

☐ COBRA/Continuation original start date:_____

Number of months eligible for COBRA
☐ 18 ☐ 29 ☐ 36

*Supporting Documentation Required

4 TYPE OF CHANGE

Add Dependent(s)
☐ Open Enrollment ☐ Newborn*
☐ Marriage* ☐ Adoption*
☐ Loss of coverage*
☐ Other_____

Drop Dependent(s)
☐ Open Enrollment
☐ Divorce*
☐ Obtained other coverage
☐ Age Limit Exceeded
☐ Other_____

General
☐ Name
☐ Address
☐ Telephone
☐ Other_____

*Supporting Documentation Required

5 TERMINATION

☐ Open Enrollment
☐ Termination of Employment
☐ Qualifying Event
☐ Term COBRA/Continuation
☐ Anticipation of Divorce
☐ Other_____

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
☐ A ☐ D	Spouse			☐ M ☐ F	
☐ A ☐ D	Child 1			☐ M ☐ F	
☐ A ☐ D	Child 2			☐ M ☐ F	
☐ A ☐ D	Child 3			☐ M ☐ 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)

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 _____

8 OTHER HEALTH COVERAGE (This section must be completed)

Is your spouse employed?..... ☐ Yes ☐ 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?..... ☐ Yes ☐ No

9 TERMS AND CONDITIONS

- 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. 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 Bluegrass Family Health, Inc. Upon such acceptance, Bluegrass Family Health, Inc. 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 Bluegrass Family Health, Inc. 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 purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. KRS § 304.47-020; IC § 35-43-5-3.4; TCA §§ 56-53-1-2 and 103.
- It is additionally a crime to knowingly or intentionally obtain, possess, transfer, or use the identifying information of another person with intent to harm or defraud another person or entity, including with the intent to fraudulently obtain or attempt to obtain money, credit, goods, services or medical information in the name of another person without that person's consent. Penalties include imprisonment, fines and denial of insurance benefits. KRS § 514.160; IC 35-43-5-3.5; TCA § 39-14-150.

Employee Name (please print) **Employee Signature** **Date**