BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Health Change Application

MCMS, Inc.-Insurance Trust Fund
Collier Associate Members

Please type or write clearly in black or blue ink.

Section A: Current Information

Group Name:	**Group #:**	**Division #:**

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 ☐ Birth ☐ Death ☐ Divorce ☐ Leave of Absence ☐ Loss of Coverage ☐ Marriage ☐ Medicare Eligible ☐ Ineligibility of Dependent Child ☐ Reduction of Hours ☐ Retirement ☐ Return of Alternate Insurance ☐ Termination

Change Request Type:	☐ New Name:	
	☐ New Address:	☐ New Phone #:

Plan Coverage Type Requested: ☐Add Health (make selection below) ☐Delete Health ☐Change Plan (make selection below)

Employee Plan Choices:	☐**B** ☐**C** ☐**I** ☐**L** (HSA Plans) ☐**G** ☐**H** ☐**M**
Physician (owner/partner) Plan Choices:	☐**D** ☐**E** (HSA Plans) ☐**F** ☐**K**
Coverage Level Requested:	☐Employee ☐Family
☐Dependent Change *Complete Section C*	☐ Other Change

Primary Care Physician Name (First, Last): *HMO Only (Plan L & Plan M)*	Existing Patient: *HMO Only* ☐Yes ☐No

Section C: Dependent Information - *Attach separate sheet if additional space is needed for dependent information, sign & date.*

Last Name *(if different than employee),* **First Name, M.I.**	**Social Security Number:**	**Birth Date:**	**Relation to You**			**Sex (M or F)**	**Check if Disabled**
			Spouse (S)	**Child (C)**	**Other (O)***		

List the name of each dependent listed above that is married or has dependent child(ren) or lives outside of Florida.

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

Section D: 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?
☐ No ☐ Yes BCBSF Contract#_____

Section E: Change Authorization

Employee Signature: Date:

Employer Signature: Date: