

# 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

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				
				<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Type of Contract				Retired		Disabled		Email Address
<input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Group #	Sub Group #
Group Name	
Hire Date	
Effective Date of Enrollment/Change	

<input type="checkbox"/> <b>ENROLL</b> ___ Open Enrollment ___ New Hire ___ Rehire * ___ Loss of other coverage ___ COBRA/Continuation original start date: _____ number of months eligible (circle one) 18    29    36	<input type="checkbox"/> <b>CANCEL</b> ___ Open Enrollment ___ Termination of Employment * ___ Qualifying Event ___ Term COBRA/Continuation ___ Other: _____	<input type="checkbox"/> <b>CHANGE</b> <b>Add Dependent(s)</b> ___ Open Enrollment ___ Newborn * ___ Marriage * ___ Loss of other coverage * ___ Adoption ___ Other: _____	<b>Drop Dependent(s)</b> ___ Open Enrollment * ___ Divorce * ___ Obtained other coverage ___ Age Limit Exceeded ___ Other: _____	<b>General</b> ___ Name ___ Address ___ Telephone ___ Other: _____
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\*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				

### 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 \_\_\_\_\_