



# Guide for Group Administration

Helpful information for coordinating employee health care benefits



*Florida Blue*  

An Independent Licensee of the  
Blue Cross and Blue Shield Association

*tru*li    
for health A Florida Blue Affiliate

# Table of Contents

Introduction .....	1
HIPAA-AS Privacy Compliance .....	2
Completing Forms .....	3
Eligibility Information .....	5
Enrollment Information .....	8
Coordination of Benefits .....	18
Miscellaneous Changes .....	19
Time-Saving Health Resources .....	20
Time-Saving Benefit Administrator Resources .....	21
The BlueCard® Program .....	22
Termination of an Individual's Coverage .....	23
Continuation of Coverage .....	24
Premium Payments .....	26

## Contact Information

### Florida Blue

**Florida Blue Website Address:**  
floridablue.com

#### Membership & Billing:

ATTN: Membership & Billing  
Florida Blue  
P.O. Box 44144  
Jacksonville, FL 32231-4144

Support Services (toll-free): 1-866-946-2583  
Fax: 1-904-997-5471  
Email: GrpEMB@bcbsfl.com  
(requires group number in subject line)

#### Premium Payments:

Florida Blue  
P.O. Box 660299  
Dallas, TX 75266-0299

### Truli for Health

truliforhealth.com

#### Membership and Billing

Truli for Health  
ATTN: Group EM&B  
P.O. Box 45014  
Jacksonville, FL 32232

#### Support Services (toll-free):

1-844-677-4822 Fax: 1-904-301-1649  
Email: GRPEMB@truliforhealth.com  
(requires group number in subject line)

#### Premium Payments:

Truli for Health  
P.O. Box 660299  
Dallas, TX 75266-0299

### Florida Blue /Truli for Health

#### Express Mail Deliveries:

ATTN: Corporate Cash Receipts  
4800 Deerwood Campus Parkway DCC1-3  
Jacksonville, FL 32246-6498

#### Continuation Coverage:

Support Services (toll-free): 1-855-509-1678  
Email: ContinuationOfCoverage@floridablue.com

#### Continuant Premium Payments:

ATTN: Florida Blue or Truli for Health or  
FHICCA/COBRA  
P.O. Box 45272  
Jacksonville, FL 32232-5272

#### Continuation Express Mail Deliveries:

ATTN: Corporate Cash Receipts/COBRA  
4800 Deerwood Campus Parkway DCC1-3  
Jacksonville, FL 32246-6498

#### Plan Benefit Details:

Refer to the member's ID card for the appropriate customer service telephone number.

## Introduction

Thank you for selecting Florida Blue, Florida Blue HMO, and/or Truli for Health for your health care Coverage needs. This guide contains information to help you administer your group health care coverage program.

When you see the words “we” or “us” or “our” appearing in this guide, they refer to Florida Blue, Florida Blue HMO, or Truli for Health. The words “you” or “your” refer to the Group Administrator or the individual who has been assigned the duties of group administration. Other terms you will see used in this guide are:

- **Covered Employee**

This means an eligible employee who meets and continues to meet all applicable eligibility requirements and who is enrolled and actually covered under the Group Master Policy (with us) other than as a Covered Dependent.

- **Covered Dependent**

This means an eligible dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled and actually covered under the Group Master Policy (with us) other than as a Covered Employee.

- **Group Master Policy  
(Group Plan/Group Contract)**

This means the written document and any applicable application forms, schedules and endorsements which are evidence of, and are, the entire agreement between the group and Florida Blue/Florida Blue HMO/Truli for Health whereby Coverage and/or benefits will be provided to Covered Employees and Covered Dependents.

This guide explains Eligibility and Membership, Employee Changes, Applications and the Payment Remittance process. Your Sales/Service Representative, Agent or your Service Advocate can review any instructions with you.

This employer guide may be used for any small group or large group health care product sold by us which includes: any Health Maintenance Organization (HMO) - BlueCare, SimplyBlue and Truli for Health; Preferred Provider Organization (PPO) - BlueChoice and BlueOptions; PPO and Exclusive Provider Organization (EPO) - BlueSelect and BlueOptions (Small Group only).

Sometimes procedures for HMO products vary from non-HMO products. For this reason, this guide may contain different instructions for different product offerings. Where instructions vary, the guide will explain which product the instructions apply to.

**Note:** This guide does not replace or override the information contained within the Group Master Policy. This guide does not cover information about ancillary products such as life, dental, long-term care or vision insurance Coverage.

For our Representative to talk to, give information to, or accept information from a group, the Group Administrator’s name (or Benefit Administrator – BA) must be on file with us. If there is a change in a BA or you need to add a BA’s name, please submit a letter (on letterhead, signed by the Decision Maker) to your Service Advocate. If there is a change in Decision Maker, please contact your Sales Representative. If you or your employees have questions other than enrollment issues, please contact customer service.

## HIPAA-AS Privacy Compliance

The Privacy Rule of the Health Insurance Portability and Accountability Act-Administrative Simplification ("HIPAA-AS") considers health plans as "covered entities" that must comply with the Privacy Rule. Health Plans include health, dental, vision, and prescription drug insurers, health maintenance organizations ("HMOs"), Medicare, Medicaid, Medicare Advantage, Medicare Part D, Medicare supplement insurers, and long-term care insurers. Health plans also include group health plans that provide or pay the cost of medical care. A group health plan is established, by virtue of law, through the plan documents. As a group health plan, you may be accountable for complying with the HIPAA-AS Privacy Rule. The degree to which your group health plan is subject to the law depends on whether your employer provides health benefits solely through an insurance contract with a health insurer issuer, such as Florida Blue, or an HMO, such as Florida Blue HMO or Truli for Health, and whether or not the employer group creates or receives Protected Health Information (PHI) other than as allowed under the HIPAA-AS Privacy Rule.

If you are a fully-insured group health plan that provides health benefits through an insurance or HMO contract with us and do not create or receive PHI other than as permitted under the law, you may rely on your relationship with us to manage your Privacy Rule compliance requirements. The sharing of PHI between us and the group health plan is limited to enrollment/disenrollment information and summary health information in order for you to obtain premium bids for providing health Coverage through your group health plan, or to modify, amend, or terminate your group health plan. The Privacy Rule compliance requirements that we may manage include, as an example, distribution of a Privacy Notice, managing requests for a Confidential Communication address, access to records, amendment requests, handling privacy complaints, and, through our Privacy Office, applying our policies and procedures to all matters involving PHI that we administer for our fully-insured group health plan customers.

If you are a self-funded group health plan and/or

create or receive PHI other than as the law permits for enrollment/disenrollment and summary level information, you may have additional responsibilities in order to meet HIPAA-AS requirements. A self-funded group health plan may delegate some of its requirements to a third party like us but cannot defer all the risk and is ultimately responsible for its own Privacy Rule compliance. The sharing of PHI will depend on the contractual arrangement that is in place between your group and us.

This information does not intend to dispense legal advice. If you are uncertain how the Privacy Rule applies to your organization's group health plan, please read the Privacy Rule and seek legal counsel as necessary. If you would like more information about the Privacy Rule, you can obtain information at [hhs.gov/ocr/privacy/index.html](https://hhs.gov/ocr/privacy/index.html)

## Completing Forms

When an employee initially enrolls or makes changes to existing group health Coverage, the first step is to fill out the appropriate forms. There are several forms you will need to keep on hand. A list of pertinent forms follows. Unless otherwise noted, these forms may be used for Florida Blue, Florida Blue HMO and/or Truli for Health products. Forms may be ordered by contacting your local Florida Blue and/or Truli office, Agent or Sales Representative or on our website at [floridablue.com/employers](http://floridablue.com/employers) or [truliforhealth.com](http://truliforhealth.com).

### Form Name

1. Employee Enrollment Application  
22095 (Page 14)

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2. Employee Notification  
22411 (Page 16)

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3. Important Information Regarding Your Special Enrollment Rights  
15741 (Page 18)

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4. Group Administrator Reorder Form  
8222 (Page 4)  
\*Note: This reorder form is for individual forms only. If you need to reorder Enrollment Packages and Schedules of Benefits, etc., please contact your Sales Representative.

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5. Cobra Administration Waiver Approval Form – Form A  
81627-0719R (Page 28)

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6. Cobra Administration Waiver Approval Form – Form C  
81628-0719R (Page 29)

Please be advised forms are subject to change. Please verify with your Sales/Service Representative, Service Advocate or Agent regarding changes or updates to the forms.



## GROUP ADMINISTRATOR REORDER FORM

Please use this Group Administrator Reorder form for ordering additional forms. (A listing of frequently used forms is on the previous page.)

### I. Instructions

- A. Order forms 1 to 2 weeks before your current supply is depleted.
- B. Order a supply of forms that will last you 1 to 2 months.
- C. Identify the quantity and the type of forms that you need by completing section II below. The form number shown on the form(s) that is being requested must be written on this reorder form.
- D. Complete section III below with the complete name, address, city, state and zip code of the company/facility that is to receive the form(s). Also, indicate the name of the person who is to receive the forms(s).
- E. Return this reorder form to:  
ATTN: Materials Management  
Florida Blue  
P.O. Box 1798  
Jacksonville, FL 32231-0014  
or FAX to: (904) 791-6993
- F. Who may we contact if we have questions concerning your order?

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### II. Quantity Form #

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### III. Ship forms to: (No P.O. Boxes Please)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Eligibility Information

### Eligibility Requirements

Eligibility is determined and effective dates are assigned upon completion of the eligibility waiting period. The Coverage Effective Date will be the first or fifteenth (your bill date) of the following month after the employee completes the eligibility waiting period, unless otherwise specified in the Group Application. **The Employee Enrollment Application must be received within 30 days of the enrollment effective date.**

If the application is received more than 30 days from the enrollment effective date, the employee must wait to re-apply at the Annual Open Enrollment (if applicable) unless due to loss of coverage under Healthy Kids, Children's Health Insurance Plan (CHIP), or Medicaid, in which case, the employee has 60 days to re-apply or they may join the group plan if they experience a Special Enrollment event as defined by the Health Insurance Portability and Accountability Act (HIPAA). The following are examples of Special Enrollment events:

1. Involuntary loss of Coverage due to:
  - a. death;
  - b. divorce;
  - c. termination of employment;
  - d. reduction of hours of employment; or
  - e. Coverage termination as a result of termination of employer contributions;
2. marriage;
3. birth of a child; and
4. adoption or placement for adoption.

Please see the Special Enrollment section of this guide for further information.

**Note:** If a part-time employee has moved to full-time status, an Employee Enrollment Application must be submitted, including the full-time date of hire. The employee must satisfy the appropriate waiting period, unless otherwise specified.

### Types of Coverage

A Coverage code is assigned to each Covered Employee for the Coverage selected. Listed below are the Coverage codes and a description for each:

- 01 – Employee
- 02 – Employee/Family
- 03 – 2 Person (Employee and 1 dependent, either spouse/domestic partner or child)\*
- 04 – Employee/Child\*
- 06 – Employee/Children\*
- 07 – Employee/Spouse or Domestic Partner\*

These Coverage codes are listed in the "CVG" category on your group invoice.

*\*Only applicable if you have purchased this option for your group.*

## How Eligibility is Determined

### Covered Employee Eligibility

To be eligible to enroll for Coverage under us, a person must:

1. be a bona fide employee of the Group;
2. have a job which falls within a job classification on the Group Application;
3. work for the Group at least the weekly number of hours specified on the Group Application. Part-time, temporary or substitute employees are not eligible;
4. reside in, or be employed in, the service area ([BlueCare](#), [SimplyBlue](#), [BlueSelect](#) and [Truli for Health products only](#)); and
5. complete any applicable eligibility waiting period specified on the Group Application.

### Dependent Eligibility

#### Federal Law:

Health care reform legislation makes coverage available to adult children up to age 26 for plan years beginning with a group's renewal after September 23, 2010, no dependent eligibility requirements can apply from newborn to 26.

#### State Law:

Requires that extended coverage for overaged dependents be offered to the policyholder (group) through the end of the calendar year in which they reach age 30. No dependent eligibility requirements can apply on newborns to age 26 (Federal law).

Florida's over age dependent mandate law requires that eligibility requirements for dependents between ages 26 and 30 can only be equal to or less than the requirements stated in the law. Those dependent eligibility requirements are:

A Covered Dependent child may continue coverage beyond the age of 26, provided he or she is:

1. Unmarried and does not have a dependent;
2. A Florida resident or a full-time or part-time student;
3. Not enrolled in any other health coverage policy or plan;
4. Not entitled to benefits under Title XVIII of the Social Security Act unless the child is an intellectually or physically disabled dependent child.

This Coverage will terminate on the last day of the month in which the child no longer meets the requirements for eligibility.

#### Florida Blue and/or Truli for Health:

Our standard eligibility criteria for dependents are defined as follows:

- Dependents are covered through the end of the calendar year they reach age 30 with no qualifications or coverage restrictions. (Note: Once a Foster Child is no longer in the "Foster Child Program" then he/she is not eligible for coverage under the Foster Parent.)
- Large groups may have the flexibility to "opt out" and limit dependent coverage to the end of the calendar year the dependent reaches age 26 with no qualifications or coverage restrictions.
- Large groups may also elect to provide coverage to age 30, but apply Florida Statute dependent eligibility criteria to dependents between the ages of 27 – 30.

**Note:** The term "child" includes the Covered Employee's child(ren), newborn child(ren), stepchild(ren), legally adopted child(ren), or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian.

- \* Ex-spouses are not eligible dependents even if Coverage is court ordered. However, ex-spouses may be eligible for continuation of coverage. Refer to COBRA FAQ for more details.



## Dependent Eligibility Verification

We conduct an annual review to verify Coverage for over age dependents. It is the responsibility of the Group Administrator to terminate these dependents based on their contractual agreement with us. The purpose of this verification is to inform the Groups of dependents currently covered by parents or guardians who participate in their employer's group health plan. Proper maintenance of eligibility assures that the dependent will be terminated if no longer eligible due to meeting the dependent eligibility age limit; or continue to be covered under the group health plan, if applicable.

## Disability Status

We will continue Coverage for a Covered Employee's intellectually or physically disabled dependent child beyond the limiting age, as a Covered Dependent, if the child is eligible for Coverage under the Group Master Policy and is actually enrolled. The dependent child must be incapable of self-sustaining employment by reason of intellectual disability or physical disability, and be chiefly dependent upon the Covered Employee for support and maintenance. The symptoms or causes of the child's intellectual or physical disability must have existed prior to the child reaching the limiting age of the Coverage. This eligibility shall terminate on the last day of the month in which the child does not meet the requirements.

**Note:** It is the Covered Employee's sole responsibility to establish that an intellectually or physically disabled child meets the applicable requirements for eligibility.

A **physician's letter**, verifying this information, will need to be mailed to DEV Processing, PO Box 44144, Jacksonville, FL 32231-9879.

## Dependents on Medical Leave

## of Absence

A Covered Dependent child who is a full-time or part-time student at an accredited post-secondary institution, who takes a Physician-certified Medically Necessary leave of absence from school, will still be considered a student for eligibility purposes under the Group Master Policy for the earlier of 12 months from the first day of the leave of absence, or the date the Covered Dependent would otherwise no longer be eligible for coverage under this Contract.

## Retired Employees

If your group is not required by Florida law to provide Coverage for retired employees, you must terminate those retiring employees from your group plan when they are no longer eligible for Coverage.

# Enrollment Information

## New Enrollment

Permanent, full-time employees, as defined by your Group Master Policy, should complete the Employee Enrollment Application on the first day of employment. Applications should be submitted to us at that time. Be advised that the employee's Effective Date of Coverage will be determined after the eligibility waiting period has been satisfied. Prompt submission will ensure that your employees receive their ID cards by their effective date.

If an employee terminates employment prior to completing their eligibility waiting period, notify us by phone, fax, in writing, or email and we will withdraw that employee's application.

## Enrollment Periods

The enrollment periods for applying for Coverage are as follows:

- **Initial Enrollment Period** – the period of time during which an eligible employee or eligible dependent is first eligible to enroll. It starts on the eligible employee's or eligible dependent's initial date of eligibility and ends no less than 30 days later.
- **Annual Open Enrollment Period\*** – an annual 30-day period occurring no less than 30 days **prior to** the group anniversary date, during which each eligible employee is given an opportunity to select Coverage from among the alternatives included in the group's health benefit program.
- **Special Enrollment Period** – the 30-day period of time immediately following a special event during which an eligible employee or eligible dependent may apply for Coverage. Special events are described in the Special Enrollment Period subsection.

\* The Annual Open Enrollment Period may not apply to certain groups.

## Employee Enrollment

An individual who is an eligible employee on the group's Effective Date must enroll during the Initial Enrollment Period, unless the employee declines Coverage. The eligible employee shall become a Covered Employee as of the Effective Date of the group. Eligible dependents may also be enrolled during the Initial Enrollment Period. The Effective Date of Coverage for an eligible dependent(s) shall be the same as the Covered Employee's effective date.

An individual who becomes an eligible employee after the group's Effective Date (for example, newly hired employees) must enroll before or within their Initial Enrollment Period. The Effective Date of Coverage for such an individual will be determined in accordance with the Group Application.

## Dependent Enrollment

An individual may be added upon becoming an eligible dependent of a Covered Employee.

**Note:** Coverage changes should not be deducted from, or added to, the group invoice.

For adoption, foster children, legal or temporary guardianship or court order, proper court documentation must be submitted. Notarized statements and powers of attorney are not valid.

**Newborn Child** – To enroll a newborn child who is an eligible dependent, the Covered Employee must complete and submit to you an Employee Notification. The Effective Date of Coverage will be the date of birth. You must forward the Employee Notification to us for processing.

If we receive the Employee Notification from you within 30 days after the date of birth of the child, then no premium will be charged for the first 30 days of Coverage for the newborn child. [Therefore, it is important to notify your employees to submit the Employee Notification to you as soon as possible after the date of birth of a child because we must receive the form within 30 days of the date of birth in order for the premium payment to be waived for the first 30 days of Coverage.](#) If we receive the Employee Notification 31 - 60 days after the date of birth, then premium will be charged back to the date of birth.

If the Covered Employee submits the Employee Notification more than 60 days after the date of birth and the Annual Open Enrollment has not occurred since the date of birth, the Covered Employee may still apply for Coverage for the newborn child. Premium will then be charged back to the date of birth. Section 125 groups are only allowed 60 days from the date of birth to submit the child's information to us for enrollment. Otherwise the Covered Employee will have to wait until open enrollment.

If the Covered Employee submits the Employee Notification more than 60 days after the date of birth and the Annual Open Enrollment has occurred, the newborn child may not be added until the next Annual Open Enrollment Period or Special Enrollment Period.

The guidelines above only apply to newborns born after the Effective Date of the Covered Employee. If a child is born before the Effective Date of the Covered Employee and was not added during the Initial Enrollment Period, we must receive the Employee Notification within 60 days after the birth of the child and any applicable Premium must be paid back to the Effective Date of Coverage of the Covered Employee. In the event we are not notified within 60 days of the birth of the newborn child, the Covered Employee must submit the application during an Annual Open Enrollment Period or Special Enrollment Period.

**Grandchild/Dependent of a Dependent** – The dependent parent must have been covered at the time of birth for the Covered Employee's grandchild to be covered from the date of birth. Grandchildren (dependent of a dependent) may remain on the contract, up to 18 months of age, even if the dependent parent terminates.

Please refer to the Newborn Child section under Dependent Enrollment for enrollment rules and timelines.

**Note:** [Coverage for a newborn child of a Covered Dependent other than the Covered Employee's spouse will automatically terminate 18 months after the birth of the newborn child.](#)

**Adopted Newborn Child** – To enroll an adopted newborn child, the Covered Employee must complete and submit to you the Employee Notification and a copy of the final adoption decree from the court. The Effective Date of Coverage will be the date of birth, provided a written agreement to adopt the child has been entered into by the Covered Employee prior to the birth of the child. You must forward the Employee Notification along with a copy of the final adoption decree from the court to us for processing.

If we receive the Employee Notification within 30 days after the date of birth of the adopted newborn child, then no premium will be charged for the first 30 days of Coverage for the adopted newborn child. [Therefore, it is important to notify your employees to submit the Employee Notification to you as soon as possible after the date of birth of an adopted newborn child because we must receive the form within 30 days of the date of birth in order for the premium payment to be waived for the first 30 days of Coverage.](#) If we receive the Employee Notification 31 - 60 days after the date of birth of the adopted newborn child, then premium will be charged back to the date of birth. We may require the Covered Employee to provide additional information or documents other than the Employee Notification and a copy of the adoption decree from the court which we deem necessary to properly administer this provision.

If the Covered Employee submits the Employee Notification more than 60 days after the date of birth and the Annual Open Enrollment has not occurred since the date of birth, the Covered Employee may still apply for Coverage for the adopted newborn child. Premium will then be charged back to the date of birth.

If the Covered Employee submits the Employee Notification more than 60 days after the date of birth and the Annual Open Enrollment has occurred, the adopted newborn child may not be added until the next Annual Open Enrollment Period or Special Enrollment Period.

The guidelines above only apply to adopted newborns born after the Effective Date of the Covered Employee. If a child is born before the Effective Date of the Covered Employee and was not added during the Initial Enrollment Period, we must receive the Employee Notification within 60 days after the birth of the child and any applicable Premium must be paid back to the Effective Date of Coverage of the Covered Employee. In the event we are not notified within 60 days of the birth of the adopted newborn child, the Covered Employee must make application during an Annual Open Enrollment Period or Special Enrollment Period.

If the adopted newborn child is not ultimately placed in the residence of the Covered Employee, there shall be no Coverage for the adopted newborn child. It is the responsibility of the Covered Employee to notify us within 10 calendar days if the adopted newborn child is not placed in the residence of the Covered Employee.

**Adopted/Foster Children** – To enroll an adopted or foster child, the Covered Employee must complete and submit to you the Employee Notification along with a copy of the final adoption decree from the court or applicable court documentation. The Effective Date for an adopted or foster child (other than an adopted newborn child) shall be the date the adopted or foster child is placed in the residence of the Covered Employee in compliance with Florida law. You must forward the Employee Notification and a copy of the final adoption decree from the court or applicable court documentation to us for processing. If we receive the Employee Notification and final adoption decree from the court within 30 days of the date of placement for an adopted child, then no additional premium will

be charged for Coverage of the adopted child for the first 30 days of Coverage. In the case of a foster child, the Employee Notification and applicable court documentation should be sent to Florida Blue/Florida Blue HMO and/or Truli for Health along with the applicable premium payment for the first 30 days of Coverage. [There is no waiver of premium provision for foster children.](#)

If the Covered Employee has not submitted the Employee Notification within 30 days of the date of placement, the Covered Employee may still apply for Coverage for an adopted child or foster child. The Employee Notification, however, must be received by us within 60 days of the date of placement of the adopted or foster child. This means: (1) the Covered Employee must have completed the Employee Notification and submitted it to you along with a copy of the final adoption decree from the court or applicable court documentation; and (2) you have sent the forms to us; and (3) it has been received by us within 60 days from the date of placement of the adopted or foster child. Additionally, all premium payments must be paid back to the date of placement. In the event we do not receive the Employee Notification before or within the 60-day period after the date of placement of the adopted or foster child, the Covered Employee will have to wait to enroll the child during the next Annual Open Enrollment Period or Special Enrollment Period.

For all children Covered as adopted children, if the final decree of adoption is not issued, Coverage shall not be continued for the proposed adopted child. Proof of final adoption must be submitted to us. It is the responsibility of the Covered Employee to notify us if the adoption does not take place. Upon receipt of this notification, we will terminate the Coverage of the child on the first billing date following receipt of the written notice.

If the Covered Employee's status as a foster parent is terminated, Coverage shall not be continued for any foster child. It is the responsibility of the Covered Employee to notify us that the foster child is no longer in the Covered Employee's care. Upon receipt of this notification, we will terminate the Coverage of the child on the first billing date following receipt of the written notice.

**Marital Status** – A Covered Employee may apply for Coverage for an eligible dependent(s) due to marriage. To apply for Coverage, the Covered Employee must complete the Employee Notification and submit it to you. You must then send the Employee Notification to us for processing. The Employee Notification must be received by us within 30 days of the date of the marriage. The Effective Date of Coverage for an eligible dependent(s) who is enrolled as a result of marriage is the date of the marriage. Please note that as of January 5, 2015, all Florida Blue and/or Truli for Health insured groups must allow all legally married spouses to enroll in coverage regardless of the couple being same or opposite sex.

**Court Order** – An eligible employee may apply for Coverage for an eligible dependent\* outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered Coverage to be provided for a minor child under the eligible employee's plan. To apply for Coverage, the eligible employee must complete the Employee Notification, if covered, and submit it to you. You must forward the Employee Notification along with a copy of the court order signed by a judge to us for processing. We must receive the Employee Notification and a copy of the court order within 30 days of the court order. The Effective Date of Coverage for an eligible dependent who is enrolled as a result of a court order is the date required by the court or the next billing date.

\*The dependent must be named on the court order. If not named on the court order, application for Coverage must wait until the Annual Open Enrollment Period.

## Annual Open Enrollment Period (If Applicable\*)

Eligible employees and/or eligible dependents who did not apply for Coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for Coverage during an Annual Open Enrollment Period. The eligible employee may enroll himself/herself (and any eligible dependents) during the Annual Open Enrollment Period by completing the Employee Enrollment Application during the Annual Open Enrollment Period. If a Covered Employee chooses to change products offered by the group and us, or, if an employee is already a Covered Employee and only wishes to enroll an eligible dependent(s), the Covered Employee should complete and submit the Employee Notification. The Covered Employee should submit this form to you and you must forward it to us for processing. This form must be received by us during the Annual Open Enrollment Period.

Eligible employees who do not enroll or change their Coverage selection during the Annual Open Enrollment Period must wait until the next Annual Open Enrollment Period, unless the eligible employee is enrolled due to a special event as outlined in the Special Enrollment Period subsection of this section.

\* The Annual Open Enrollment Period may not apply to certain groups.

## Special Enrollment Period

To apply for Coverage, the eligible employee must complete the applicable enrollment form and forward

it to you within 30 days of the special event. Eligible dependents may be enrolled at the same time an eligible employee enrolls.

**Special Events** – An eligible employee may apply for Coverage due to the following special events: birth of a child, placement for adoption or marriage. Eligible dependents may be enrolled at the time an eligible employee enrolls. To apply for Coverage, the eligible employee must complete the Employee Enrollment Application. You must then forward the application to us for processing. The eligible employee must submit, and we must receive, the application for Special Enrollment within 30 days of the special event, except as indicated in number 4. The Effective Date of Coverage for an eligible employee and any eligible dependent(s) who are enrolled as a result of birth, adoption, placement for adoption or marriage is the date of the event and/or next billing cycle.

Eligible employees who do not enroll or change their Coverage selection during the Special Enrollment Period must wait until the next Annual Open Enrollment Period. (See the Dependent Enrollment subsection of this section for the rules relating to the enrollment of eligible dependents of a Covered Employee.)

**Loss of Eligibility for Coverage** – An eligible employee and/or eligible dependent(s) may request enrollment outside of the Initial Enrollment Period and Annual Open Enrollment Period if the individual:

1. was covered under another group health benefit plan as an employee or dependent, or was covered under other health coverage including Healthy Kids, a Children's Health Insurance Plan (CHIP), Medicare or Medicaid, or was covered under COBRA or FHICCA continuation of Coverage at the time he/she was initially eligible to enroll for Coverage under the Group Master Policy;
2. when offered Coverage at the time of initial eligibility, the individual must be provided an electronic copy or print copy of the Notice of Special Enrollment Rights by their employer, that Coverage under a group health plan or health insurance Coverage was the reason for declining

enrollment. This notice must be signed/dated by the individual declining coverage and a copy provided to the employer.

3. demonstrates that he/she has lost Coverage under a group health benefit plan or health insurance Coverage within the past 30 days as a result of: (1) legal separation, (2) divorce, (3) death, (4) termination of employment, (5) reduction in the number of hours of employment, or (6) the Coverage was terminated as a result of the termination of employer contributions toward such Coverage; and
4. requests enrollment within 30 days after the termination of Coverage under another employer health benefit plan; unless such coverage was Medicaid, CHIP or, if available in the employee's State, the employee or their dependent becomes eligible for the optional State premium assistance program, in which case they have 60 days from the date they lose coverage to request enrollment in their employer's health plan.

If an eligible employee is requesting Coverage under a Special Enrollment Period due to loss of other Coverage, the employee needs to submit the following applications/forms to you, the group administrator: Employee Enrollment Application, and a copy of the Notice of Special Enrollment Rights form.

These forms must be submitted by you and received by us within 30 days of the loss of Coverage, otherwise the employee or eligible dependent(s) must wait until the next Annual Open Enrollment period to enroll for Coverage.

An individual who loses Coverage for failure to pay his or her portion of required premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health Coverage) **does not** have the right to make application for Coverage during the Special Enrollment Period.

## Other Provisions Regarding Enrollment and Effective Date of Coverage

**Rehired Employees** – Individuals who are rehired as employees of the group are considered newly hired employees, unless the employer has indicated

that the employee qualifies for the exception as described in the federal regulations. The provisions of the Group Master Policy which are applicable to newly hired employees and their eligible dependents (e.g., Enrollment, Effective Dates of Coverages and Waiting Period) are applicable to rehired employees and their eligible dependents if the employee does not qualify for the federal exception.

**Premium Payments** – In those instances where an individual is to be added to the group Coverage (e.g., a new eligible employee or a new eligible dependent, including a newborn or adopted child), that individual's Coverage shall be effective, as set forth in this section, provided we receive the applicable additional premium payment within 30 days of the date we notified the group of such amount. In no event shall an individual be covered under a Group Master Policy if we do not receive the applicable premium payment within such time period.

# Employee Enrollment Application



## Employee Enrollment Application

Please type or write clearly in black or blue ink.

### Section A: Current Information

Group Name:		Group #:		Division #:		Package #:	
Effective Date of Coverage:	Date of Hire:	Location #:	Employee #:	Job Title:			
Work Status: <input type="checkbox"/> Actively at Work <input type="checkbox"/> Cobra <input type="checkbox"/> Retired		Retirement Date:		Paid: <input type="checkbox"/> Hourly <input type="checkbox"/> Salary		<input type="checkbox"/> Open Enrollment	

### Section B: Employee Information

Social Security #:	Last Name:	First Name:	M.I.:	Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:		Apt. #:	City:	State:	Zip:
County:	Phone:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated			
Physician Name / ID # <i>HMO only</i> :	Existing Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	Language of Preference: <i>optional - for data collection purposes only</i> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> Prefer not to answer			
Ethnicity <i>optional</i> <i>Check all that apply:</i> <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Caribbean Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> White					

### Section C: Health Coverage Level and Plan Information

Employee Health Coverage:  Employee  \*Employee & Spouse  \*Employee & One Dependent  \*Employee & Child(ren)  Family  
*\*When available*

<input type="checkbox"/> BlueOptions Plan # _____	<input type="checkbox"/> BlueChoice (PPO) Plan # _____	<input type="checkbox"/> BlueCare (HMO) Plan # _____
<input type="checkbox"/> BlueSelect Plan # _____	<input type="checkbox"/> Truli For Health (HMO) Plan # _____	<input type="checkbox"/> Other Plan # _____

I am Refusing all Health Coverage at this time. I understand that if I decide to apply later coverage may not be available until the next open or special enrollment period. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Section D: Vision Coverage Level and Plan Information

Employee Vision Coverage:  Employee  \*Employee & Spouse  \*Employee & One Dependent  \*Employee & Child(ren)  Family

Vision Plan Choice:

I am Refusing all Vision Coverage at this time. I understand that if I decide to apply later coverage may not be available until the next open or special enrollment period. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Section E: Dependent Information *Attach separate sheet, if additional space is needed, with dependent information, sign & date.*

Last Name: <i>(if different than employee)</i> First Name, M.I.	Social Security Number:	Birth Date:	Relation to You					Plan Type			Physician Name/ID <i>HMO only</i>	Dependent			Ethnicity <i>optional</i> <i>Circle all that apply.</i>		
			Spouse (S)	Child (C)	Domestic Partner (DP)	Domestic Part. Child (DPC)	Other (O)*	Health	Vision	Sex (M or F)		Check if Disabled	Existing Patient (Y/N)	You Support		Lives With You	Is a Student
																	A B C H N W
																	A B C H N W
																	A B C H N W
																	A B C H N W

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:



## Employee Enrollment Application

**Section F: 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 Florida Blue and/or Truli for Health) that will be in effect after this coverage begins?  Yes  No

Florida Blue and/or Truli for Health Contract # \_\_\_\_\_ Medicare # \_\_\_\_\_ Pharmacy/Medicare D # \_\_\_\_\_

Complete the following only if this is the first time you or your dependents: (1) are enrolling for health insurance with this employer; (2) currently have health coverage; and/or (3) have any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable Coverage.

Prior Health Carrier Name:		Contract #:	Effective Date:
Prior Employee Hire Date:	Cancel Date:	List names of all family members that were covered, including yourself:	
Signature:			Date:

**Section G: Acceptance of Coverage**

**Plan Coverage Terms**

I hereby apply for the coverage/membership that is selected on this form. My employer has selected health and/or vision coverage through Florida Blue and/or HMO coverage through Florida Blue HMO and/or Truli for Health.

I authorize my employer to deduct from my earnings my premium contribution, if any. I understand all of the following:

1. If my coverage/membership is to be issued and continued, I must meet all the group contract's requirements;
2. If my dependents' coverage/membership, if any, is to be issued and continued, my dependents must meet all the group contract's requirements;
3. If I must pay part or all of the premium, coverage/membership shall not become effective until Florida Blue, Florida Blue HMO and/or Truli for Health accepts this application and assigns an effective date.

I understand that membership granted to persons herein shall be subject to all provisions and limitations of the group contract.

I am aware that a change in coverage of dependents may affect the amount deducted from any wages (if any) for coverage/ membership, and I hereby authorize such a change.

If I am enrolling in a high-deductible health plan designated for use with a Health Savings Account (HSA) under Internal Revenue Service Code section 223, I recognize and authorize Florida Blue and/or Truli for Health to exchange certain limited information obtained from this application with its preferred financial partner(s) for the purposes of initial enrollment in, and administration of, HSAs.

I understand that if I am enrolling in an HSA qualified High Deductible Health Plan and I elect to receive Prior Carrier Credit under Florida law, my plan may no longer qualify as an HSA compatible plan.

**General Terms**

I AGREE that in the event of any controversy or dispute between Florida Blue, Florida Blue HMO and/or Truli for Health, I and my dependents must exhaust the appeal and/or grievance processes in the benefit/member handbook issued to me.

I understand that my employer is not an agent of Florida Blue, Florida Blue HMO and/or Truli for Health. I also understand that my employer is responsible for notifying all employees of: 1. Effective dates; 2. All termination dates; 3. Any conversion, COBRA or ERISA rights or responsibilities; and 4. All other matters pertaining to coverage/membership under the group contract.

When an overpayment is made, I authorize Florida Blue and/or Florida Blue HMO and/or Truli for Health to recover the excess from any person or entity that received it.

I acknowledge that Florida Blue, Florida Blue HMO and/or Truli for Health coverage/membership is contingent upon the complete, accurate disclosure of the information requested on this form.

I acknowledge that, if I apply for Florida Blue, Florida Blue HMO and/or Truli for Health coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period.

I represent that the statements on this application are true and complete to the best of my knowledge and belief.

I understand and agree that misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the group contract's terms and conditions.

**I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

Signature:	Date:
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Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue. HMO coverage is offered by Health Options, Inc., DBA Florida Blue HMO and/or BeHealthy Florida, Inc., DBA Truli for Health. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

22095-0919

# Employee Change Application



## Employee Change Application

Please type or write clearly in black or blue ink.

### Section A: Current Information

Group Name:	Group #:	Division #:	Package #:
Employee Name: (Last, First Name, M.I.)	Social Security #:	Effective Date of Coverage:	Date of Event:

### Section B: Coverage Change Information

Reason for Change:

<input type="checkbox"/> Adoption	<input type="checkbox"/> Death	<input type="checkbox"/> Leave of Absence/Layoff	<input type="checkbox"/> Moved from Service Area
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Section 125	<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth
<input type="checkbox"/> Over-Aged Dependent	<input type="checkbox"/> Terminate	<input type="checkbox"/> Return of Alternate Insurance	<input type="checkbox"/> Loss of Coverage
<input type="checkbox"/> Divorce	<input type="checkbox"/> Employment Location _____	<input type="checkbox"/> Employee # _____	<input type="checkbox"/> Plan Type: _____ (ex. PPO, HMO, RX)

Change Request Type:

<input type="checkbox"/> New Name:
<input type="checkbox"/> New Address:
<input type="checkbox"/> New Phone #:
<input type="checkbox"/> New Physician Name/ID:

Plan Coverage Type Requested:  Add Health  Delete Health  Add Vision  Delete Vision  Change Plan: *Indicate Plan #*

Coverage Level Requested:  Employee  \*Employee & Spouse  \*Employee & One Dependent  \*Employee & Children  Family  
\*When available

Dependent Change *Complete Section C*  Other Change:

Applicable to Group Administrator: The Affordable Care Act prohibits rescissions; cancellations cannot be submitted for the period in which a premium is collected. By submitting cancellation(s) you represent that you have not collected a premium from the employees/dependents for coverage after the requested termination date.

### Section C: Dependent Information *Attach separate sheet, if additional space is needed, with dependent information, sign and date.*

Last Name: <i>(if different than employee)</i> First Name, M.I.	Social Security Number	Birth Date	Relation to You			Plan Type		Sex (M or F)	Check if Disabled	Physician Name/ID <i>HMO only</i>	Dependent Existing Patient (Y/N)	Dependent			Ethnicity <i>optional</i> <i>Check all that apply.</i> A - Asian/Pacific Islander B - Black/African American C - Caribbean Islander H - Hispanic N - Native American W - White
			Spouse (S)	Child (C)	Other (O)*	Health	Vision					You Support	Lives With You	Is a Student	
						<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> N <input type="checkbox"/> W
						<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> N <input type="checkbox"/> W
						<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> N <input type="checkbox"/> W
						<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> N <input type="checkbox"/> W

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 Florida Blue and/or Truli for Health plans) that will be in effect after this coverage begins?  Yes  No  
Florida Blue and/or Truli for Health Contract # \_\_\_\_\_ Medicare # \_\_\_\_\_ Pharmacy/Medicare D # \_\_\_\_\_

Complete the following only if this is the first time you or your dependents: (1) are enrolling for health insurance with this employer; (2) currently have health coverage; and/or (3) have any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable Coverage. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Prior Health Carrier Name	Contract #:	Effective Date:
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Prior Employee Hire Date:	Cancel Date:	List names of all family members that were covered, including yourself:
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Employee Signature:	Date:
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Employer Signature:	Date:
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Section E: Change Authorization

**Plan Coverage Terms**

I hereby authorize the changes to my Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue, Health Options, Inc., DBA Florida Blue HMO and/or BeHealthy Florida, Inc. DBA Truli for Health contract that is selected on this form. I understand and agree that the changes will not be effective until this application is accepted by Florida Blue, Florida Blue HMO and/or Truli for Health.

I authorize my employer to deduct from my earnings my premium contribution, if any, including any additional amounts required as a result of the changes indicated on this Health Change Application. I understand all of the following:

1. If my coverage/membership is to be issued and continued, I must meet all the group contract's requirements;
2. If my dependents' coverage/membership, if any, is to be issued and continued, my dependents must meet all the group contract's requirements;
3. If I must pay part or all of the premium, coverage/membership shall not become effective until Florida Blue, Florida Blue HMO and/or Truli for Health accepts this application and assigns an effective date.

I understand that membership granted to persons herein shall be subject to all provisions and limitations of the group contract.

I am aware that a change in coverage of dependents may affect the amount deducted from any wages (if any) for coverage/membership, and I hereby authorize such a change.

If I am enrolling in a high-deductible health plan designated for use with a Health Savings Account (HSA) under Internal Revenue Service Code section 223, I recognize and authorize Florida Blue and/or Truli for Health to exchange certain limited information obtained from this application with its preferred financial partner(s) for the purposes of initial enrollment in, and administration of, HSAs.

I understand that if I am enrolling in an HSA qualified High Deductible Health Plan and I elect to receive Prior Carrier Credit under Florida law, my plan may no longer qualify as an HSA compatible plan.

**General Terms**

I AGREE that in the event of any controversy or dispute between Florida Blue, Florida Blue HMO and/or Truli for Health, I and my dependents must exhaust the appeal and/or grievance processes in the benefit/member handbook issued to me.

I understand that my employer is not an agent of Florida Blue, Florida Blue HMO and/or Truli for Health. I also understand that my employer is responsible for notifying all employees of:

1. Effective dates;
2. All termination dates;
3. Any conversion, COBRA or ERISA rights or responsibilities; and
4. All other matters pertaining to coverage/membership under the group contract.

When an overpayment is made, I authorize Florida Blue, Florida Blue HMO and/or Truli for Health to recover the excess from any person or entity that received it.

I acknowledge that Florida Blue, Florida Blue HMO and/or Truli for Health coverage/membership is contingent upon the complete, accurate disclosure of the information requested on this form.

I acknowledge that, if I apply for Florida Blue, Florida Blue HMO and/or Truli for Health coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period.

I represent that the statements on this application are true and complete to the best of my knowledge and belief.

I understand and agree that misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the group contract's terms and conditions.

I understand that a copy of the Summary of Benefits and Coverage (SBC) can be obtained by contacting my Group Administrator.

**I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

Signature:

Date:

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue. HMO coverage is offered by Health Options, Inc., DBA Florida Blue HMO and/or BeHealthy Florida, Inc., DBA Truli for Health. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

22411-0320R

## Notice of Special Enrollment Rights



### Important information regarding your Notice of Special Enrollment Rights

You must be given a written description of special enrollment rights by the date you are offered the opportunity to enroll. Notice of Special Enrollment Rights must be given to an employee who declines group health coverage during his/her initial eligibility period. You should return a signed copy of this notice to your employer if you decline coverage because you have other health coverage.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in a health care plan offered by your employer, provided that you request enrollment, by submission of an individual application to Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI), within 30 days after the other coverage ends, unless the coverage under which you or your dependent was enrolled was Medicaid or a Children's Health Insurance Plan (CHIP), in which case you have 60 days from the date you lose coverage to request enrollment in your employer's health plan.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your dependents, provided that you request enrollment by submission of an individual application to BCBSF/HOI, within 30 days after the marriage, birth, adoption, or placement for adoption.

The effective date of coverage for an individual and/or dependents as a result of marriage, birth, adoption, or placement for adoption is the date of the event.

Additionally, you have Special Enrollment Rights if you or your dependent becomes eligible for the optional State premium assistance program, if available in your State. You must request enrollment in your employer's group health plan within 60 days of the date you become eligible for the State premium assistance program.

If you and/or your dependents decline enrollment because you have coverage under another group health plan or other health insurance coverage, you are required to complete the statement below and return it to your Group Administrator. If you fail to do so, you may not be entitled to special enrollment in your employer's group health plan when your other coverage terminates.

**Please understand that you will not be entitled to special enrollment if loss of eligibility for coverage is the result of termination of coverage for failure to pay premiums on a timely basis or for cause. Voluntary Termination of Coverage does not constitute loss of eligibility of coverage.**

**NOTE:** For purposes of clarification, cause is defined as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. Loss of eligibility for coverage is defined as loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, the discontinuance of any contributions toward the health coverage plan by the employer, or you lose coverage under Medicaid or a Children's Health Insurance Plan (CHIP).

I hereby certify that I am declining enrollment in my employer's group health plan for  myself and/or  dependents because I or they currently **have** other health care coverage; or

I hereby certify that I am declining enrollment in my employer's group health plan and I **do not** currently have other health care coverage.

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Group name

\_\_\_\_\_  
Group #

15741-0409 R SR

## Coordination of Benefits

In the event the Covered Employee or a Covered Dependent has other health care Coverage, including other coverage with us, legal provisions governing payment of benefits may apply. Ensuring that each party pays exactly its fair share, in the correct legal order, is the responsibility of the carrier's Coordination of Benefits Department.

Coordination of Benefits (COB) is important to our members, providers, and to us. Where applicable, other party liability must be established before we can determine benefits. Other health care Coverage may include Medicare, group health plans, HMO, excess, indemnity or supplemental health policies.

**With multiple Coverage, it is important that all other health care Coverage information is provided at the time of enrollment.**

Your assistance in obtaining this information will help to ensure accurate and timely processing of claims. If other health care Coverage information is not provided, the payment of claims may be delayed while the status of other health care Coverage is investigated. This applies not only to us, but also to any other health care Coverage company with whom the member has a policy.

- If the employee or a Covered Dependent has other health care coverage, Section F on the Employee Enrollment Application must be marked 'Yes' and the other insurance information provided. These fields should not be completed if the Other Health Care Coverage will cancel as of the Effective Date that we commence.
- If the member has no other health care coverage, Section F on the Employee Enrollment Application **must** be marked '**No**' and the other insurance information left blank.
- **Electronically enrolled** (automated enrollment) groups should provide this information via the Internet during their enrollment process.
- Eligible members can update other health care Coverage information at [floridablue.com](http://floridablue.com) for Florida Blue members or [truliforhealth.com](http://truliforhealth.com) Truli for Health members.\*

It is also important for the member to provide

updated information as soon as changes to existing Coverage occurs. Examples include if a member cancels his or her other health care coverage policy, a dependent's Coverage ends, or a new dependent is added. If a change occurs, the member should provide this information on [floridablue.com](http://floridablue.com), completing an Employee Notification ensuring Section D is correct, or by calling the Customer Service number on his or her member ID card.

Maintaining the most complete, accurate and up-to-date health care Coverage information is essential in helping to reduce the number of claim denials related to other Coverage. By providing us with complete information on other Coverage maintained by a Covered Employee or a Covered Dependent, you can help contain the rising cost of health care.

\* Not all groups have access to the secure member section of [floridablue.com](http://floridablue.com) and/or [truliforhealth.com](http://truliforhealth.com)

## Employees Who Decline Health Care Coverage

Employees who choose to decline health care Coverage for themselves or a dependent must Complete and sign a "Notice of Special Enrollment Rights", form # 15741. This notice informs employees and their dependents that, should their circumstances change, they may be eligible for a Special Enrollment. The form also provides a means to record whether the employee already has health care Coverage. **Employers are required by law to give their employees and/or any eligible dependents a written description of their Special Enrollment rights by the date the employee is offered the opportunity to enroll himself/herself and any dependents.** Included in this section is the "Notice of Special Enrollment Rights" form which you must give to any eligible individual (employee and/or dependent) who declines your group health Coverage during the eligible employee's initial eligibility period for the following reasons:

1. The eligible employee declines Coverage

because he/she currently has other health care Coverage, or he/she declines Coverage and he/she has no other Coverage; and/or

2. An eligible dependent(s) may choose to decline Coverage if he/she currently has other health care Coverage, even though the eligible employee has enrolled for Coverage. However, if the eligible employee declines Coverage, any eligible dependents do not have an option to enroll for Coverage.

Those persons who decline Coverage should sign and return a copy of the "Notice of Special Enrollment Rights" to you. The employee must also complete and sign the Employee Enrollment Application indicating the employee declines all Coverage. If the employee elects Coverage, but the dependents do not, the dependents should not be included on the Employee Enrollment Application. You should retain copies of the Employee Enrollment Application and "Notice of Special Enrollment Rights" forms for your records.

## Miscellaneous Changes

### Status Changes

Use the Employee Notification when a Covered Employee makes any changes to their Coverage or wants to add or terminate a dependent(s). This form must be signed by the Covered Employee and received by us prior to the requested Effective Date. Payment for the change requested should not be made until it appears on your group invoice.

### Name or Address Changes

Changes to a Covered Employee's address or name should be submitted in writing using the Employee Notification. The form should be completed where appropriate, signed and returned to us. An employee may change their address online at [floridablue.com](http://floridablue.com) for Florida Blue members or [truliforhealth.com](http://truliforhealth.com) for Truli for Health members.\*

\* Some groups are excluded.

### Primary Care Physician (PCP) Changes

[\(Applies to all HMO products\)](#)

Each individual who has Coverage in a Florida Blue HMO and/or Truli for Health product must select a Primary Care Physician. An individual may change their Primary Care Physician (PCP) at any time. All PCP changes should be made by filling out the Employee Notification; however, these changes may also be made by contacting the Customer Service department. When the individual completes the form, please ensure the reason for the change is specified.

Individuals may request a transfer to another PCP whose practice is open to new patients. The effective date of a transfer to the new PCP will depend upon when we receive your request. Requests may be made on our website at [floridablue.com](http://floridablue.com) for Florida Blue members and [truliforhealth.com](http://truliforhealth.com) for Truli for Health members. or by calling the number on the back of the members ID card.

Please be aware that some PCPs may have a 'closed panel.' If a PCP is chosen whose panel is closed, the only way the individual may have that doctor as their PCP is if the PCP and Florida Blue HMO / Truli for Health approve the addition of the member to their panel. If there are any questions regarding the availability of a PCP, please contact Customer Service.

## Time-Saving Health Resources

We make it easier and more convenient for your employees to get the health information they need. We offer a variety of value-added health resources and tools to help make managing their health care easier and less time consuming – all at no additional premium cost.

Our member websites, [floridablue.com](http://floridablue.com) and [truliforhealth.com](http://truliforhealth.com), offer members a suite of self-service health management tools that places the following features right at their finger tips.

- Online health information available 24/7. Get details about plan benefits. View claims. Check how much of their deductible and out-of-pocket max has been met. Check their HSA balance. Print a temporary ID card.
- Save money. Members can use the pharmacy shopping tool to find out where to get your prescription for less. Compare cost and quality for upcoming procedures. Generate customized reports to assist with planning and budgeting their health care dollars. Use the personalized Provider Directory to locate doctors in network to reduce their out-of-pocket expenses.
- Get and stay healthy. Our digital and wellness solutions, Better You Strides (for Florida Blue members) and Truli for Me Program (for Truli for Health members), empower your employees to take better care of themselves. By connecting each employee to a highly customized wellness plan—and rewarding them for healthy behaviors, employees can take an active role in their health. This can improve productivity, boost employee morale and reduce the cost of claims.

Convenience you can count on, 24 hours a day, 7 days a week. Florida Blue members visit [floridablue.com](http://floridablue.com), and Truli for Health members visit [truliforhealth.com](http://truliforhealth.com).

**Blue365**<sup>®1</sup> provides members with significant discounts on vision care, hearing exams and hearing aids, contact lenses, fitness centers and weight management programs.

**The Nurseline**<sup>2</sup> is available 24/7 for questions ranging from common symptoms and illnesses, children's health and allergies to diabetes, diagnostic testing and heart conditions. (Note: The Nurseline is not available for Truli for Health members.)

**Care Consultants** can help your employees understand their condition, plus help them explore treatment options, providers and costs so they're able to make the choices that are best for them.

**The Online Provider Directory** allows you and your employees to find providers, specialty and hospital affiliation.

Our members websites provide you and your employees access to a personalized provider directory. Not only is your plan/network personalized for you, you can save your preferred geographic search location for your convenience and even save a list of My Providers to save time.

*For more details on how you can provide these valuable programs to your employees, call your agent or Sales Representative today.*

<sup>1</sup>Blue365<sup>®</sup> offers access to savings on items that Members may purchase directly from independent vendors, which are different from items that are covered under your policies with Florida Blue and/or Truli for Health, its contracts with Medicare, or any other applicable federal healthcare program. To find out what is covered under your policy, call the customer service number on your member ID card. The products and services described herein are neither offered nor guaranteed under Florida Blue contract with the Medicare program. In addition, Florida Blue is not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to Florida Blue/ Truli for Health's grievance process. Blue Cross and Blue Shield Association (BCBSA) may receive payments from Blue365 vendors. Neither Florida Blue, Truli for Health nor BCBSA recommends, endorses, warrants or guarantees any specific Blue365 vendor or item.

<sup>2</sup>As a courtesy, Florida Blue has entered into an arrangement with Health Dialog<sup>®</sup> to provide our members with value-added features that include care decision support tools and services. Florida Blue has not certified or credentialed, and cannot guarantee or be held responsible for, the quality of services provided by Health Dialog. Please remember that all decisions pertaining to medical/clinical judgment should be made with your Physician or other health care provider, and Florida Blue and Health Dialog do not provide medical care or advice. The written terms of your policy, certificate or benefit booklet determine what is covered.

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# Time-Saving Benefit Administrator Resources

## Florida Blue's Enrollment Tool

As a Benefit Administrator you can quickly and easily access your group's benefit information 24 hours a day anytime you are online. Our enrollment tool will allow you to conduct year-round maintenance changes, so new hires, terminations, and qualifying events are all done with just the click of a mouse. You can also use our enrollment tool to run over three dozen related benefit, census, change history and payroll reports.

### Enrollment Tool Features and Benefits

- Replaces paper enrollment and maintenance
- Administers all of your benefits online
- Employees have access to enrollment self-service
- 24/7 benefit access
- Great reporting functionality
- Personalized training
- Conforms to your plan rules and provisions
- Dedicated customer support team
- Fast, secure and accurate
- Immediate online visibility of benefit changes

## View and Pay Invoice

View and Pay Invoice is an online invoice management system which allows online access to billing information, payment history, and reporting features that make it easy to manage your account in a secure, paperless environment.

### View and Pay Invoice Features and Benefits

- More accurate invoicing and real-time display of terminations submitted through the enrollment tool will be updated within 24 hours
- More timely processing of payments
- Consolidate multiple invoices into one statement
- Create and download invoice and payment history reports into commonly used accounting programs (e.g., Excel)
- Print invoice copies in pdf, html or csv (spreadsheet) formats

- Receive an email notification when your invoice is ready to view and pay
- 24/7 invoice access

### Three Easy Ways to Pay

- Our View and Pay Invoice website which offers flexible payment options
- Call Florida Blue toll-free at 866-946-2583 or Truli for Health at 844-677-4822 and pay over the phone
- Florida Blue Store

## EmployerPoint

[EmployerPoint](#) is the Benefit Administrator site that provides a flexible, secure, single gateway to online service capabilities. You will have greater control and management of your group benefits with this online capability.

Some of the great features of [EmployerPoint](#) are:

1. View and pay group invoice
2. Request replacement Health ID cards and benefit booklets
3. Print temporary ID cards for your employees
4. Maintain enrollment through the enrollment tool
5. View group claims (Special access required)
6. Access and pay your Invoices through View and Pay Invoice
7. View group demographics
8. View Member Enrollment Details (Electronic file transfer groups)
9. Access MyBlueInsight (Special access required)
10. Add, modify, and delete Benefit Administrator Access
11. Obtain forms and Administrator guides
12. Find helpful links to other capabilities, such as Provider Directory and Prime Rx

If you have not yet received an email with registration instructions please contact Florida Blue toll-free at 866-946-2583 or Truli for Health at 844-677-4822 to enroll in [EmployerPoint](#).



## The BlueCard® Program

When your employees travel outside of Florida, their Coverage travels with them. The BlueCard Program gives them access to the BlueCard participating providers of other independent Blue Cross and/or Blue Shield organizations throughout the United States.

As with their health plan, they won't have to fill out any claim forms or pay up front when receiving services outside of Florida (unless it's an out-of-pocket expense, non-covered service expense, or a non-participating provider service they would pay anyway). Plus, they shouldn't have to pay above the rates the local Blue Cross and/or Blue Shield organization has negotiated with doctors and Hospitals in the area.

Here are four steps to making the BlueCard Program work for your employees:

1. Employees should always carry their current member ID card for easy reference and access to service.
2. In an emergency, they should go directly to the nearest Hospital.
3. To find names and addresses of nearby doctors and Hospitals worldwide, they can visit the BlueCard Doctor and Hospital Finder website ([bcbs.com](http://bcbs.com)) or call BlueCard Access at 800-810-BLUE (2583).
4. When they arrive at the participating doctor's office or Hospital, they should present their member ID card. The doctor will recognize the suitcase logo, which will ensure that they get the in-network benefits at the level negotiated by the local Blue Plan.

**Note:** The BlueCard Program is available to BlueChoice, BlueSelect and BlueOptions members. BlueCare and SimplyBlue members have access to this program for urgent care, emergency care and short trips (less than 90 days). For short trips, the member must call their Primary Care Physician for prior authorization for non-emergency services. For extended stays (at least 90 consecutive days), BlueCare and Simply Blue members should call the number on their member ID card for eligibility information and specific locations where the Guest Membership program is available. The "Away From Home Care" (AFHC) is not available with all HMO plans - not available with Standard or Basic or with a plan that is sold with the POS Rider. Truli for Health members have access to the BlueCard program for urgent and emergency care only.

Outside of the United States, your employees have access to doctors and Hospitals in more than 200 countries and territories around the world through the BCBS Global™ Core Program.

Here's how your employees can access Coverage internationally:

1. Employees should always carry their current member ID card and should verify their international benefits with Florida Blue before leaving the United States.
2. In an emergency, they should go directly to the nearest Hospital.
3. They should call the BCBS Global™ Core Service Center at 800-810-BLUE (2583) or collect at 804-673-1177, 24 hours a day, seven days a week for information on doctors, Hospitals and other health care professionals or to receive medical assistance services around the world.
4. If they need to be hospitalized, they should call us for precertification or pre-authorization. They should use the phone number on their member ID card.
5. If they need inpatient care, they should call the BCBS Global™ Core Service Center. In most cases, they should not need to pay upfront for inpatient care at participating Hospitals except for the usual out-of-pocket expenses. The Hospital should submit the claim on their behalf.
6. They will need to pay upfront for care received from a doctor, hospital in an outpatient setting and/or non-participating hospital. Then, they should complete an international claim form and send it with the bill(s) to the BCBS Global™ Core Service Center (the address is on the form). The claim form is available from Florida Blue, the BCBS Global™ Core Service Center or online at [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com).

**Note:** HMO members including BlueCare, SimplyBlue and Truli for Health have access to Global services for urgent and emergency care only.

## Termination of an Individual's Coverage

### Employee Cancellations/Terminations

To terminate an employee's group health Coverage, please submit the request either by faxing or mailing an Employee Notification, or by an email, telephone call, written request, listing them on the back of the most current group invoice, or you may terminate the employee yourself via our available online eTools.

**If an employee has worked for any portion of that month, they must be paid for through the end of that billing cycle (the first or fifteenth)\*.**

Terminations of employees' Coverage should be reported as soon as an employee is terminated. Terminations of Coverage will be accepted through the end of the month in which the employee is terminated. If claims activity has occurred, we will request a refund for any claims paid for the employee and/or dependents whose Coverage has been terminated. Late reporting of terminations of employees' Coverage will not be accepted and will not be effective until the following month. Only one month's premium for each employee who has been terminated may be deducted on a group invoice.

The Affordable Care Act prohibits rescissions; cancellations cannot be submitted for the period in which a premium is collected. By submitting cancellation(s) you represent that you have not collected a premium from the employees/dependents for coverage after the requested termination date.

If an employee is terminated due to death and the employee had single Coverage, the cancellation date will be the day after death. If the Coverage includes dependents, the termination will be the end of the billing cycle, or if requested, the day after death.

**Note:** If cancelling the employee plus dependent coverage, the cancel date will be the next billing cycle (the first or fifteenth).

\*Or Group specific date.

### Dependent Cancellations/Terminations

In the event the Covered Employee wishes to delete a Covered Dependent from Coverage, the employee must complete and sign an Employee Notification and submit it to you. The form must be submitted by you and sent to us. The change will be effective on the group's billing cycle\* (the first or fifteenth) following receipt and acceptance by us.

In the event the Covered Employee wishes to terminate a spouse's Coverage (e.g., in the case of divorce), the Covered Employee must submit the Employee Notification to you prior to the requested termination date or within 30 days of the date the divorce is final, whichever is applicable. If the request is not received within 30 days of the divorce, the Effective Date of the termination will be according to the group's billing cycle (the first or fifteenth)\* following receipt and acceptance by us.

The Affordable Care Act prohibits rescissions; cancellations cannot be submitted for the period in which a premium is collected. By submitting cancellation(s) you represent that you have not collected a premium from the employees/dependents for coverage after the requested termination date.

## Premium PaymentsPayment Remittance

Your group invoice will be available approximately 10 days prior to the due date. Your invoice will only be available electronically through the View & Pay Invoice tool. Please ensure you have access to View & Pay Invoice through the EmployerPoint online benefit administrator portal to obtain your invoice. Payment of premium should be remitted by the group invoice due date. [Please pay your invoice electronically; however, if you need to submit your payment using a paper check or money order, write the invoice number and your group number on the check or money order.](#) Please do not add names to the group invoice or pay for an employee whose name does not appear on the group invoice. Please pay the amount due, less any contract terminations, if applicable. No other Coverage changes should be deducted from, or added to, the group invoice.

If the premium payment is not received prior to the 30th day past the due date of the invoice, the Group Master Policy will be canceled for non-payment of premium. Letters will be mailed throughout the delinquency period notifying the Group Administrator/Decision Maker of the pending cancellation. Therefore, it is imperative that you remit your premium payment within 10 days of the premium due date as indicated in your Group Master Policy. This will ensure prompt and accurate reconciliation of your payment and avoid potential claims from possibly being held or denied.

## Continuation of Coverage

### COBRA

#### Federal (Group size 20 or more eligible employees)

**If your group size is 20 or more eligible employees (for 50 percent or more of the previous calendar year),** Federal law requires you to comply with Federal COBRA. Once your group is set up with us, you will receive an information packet and all inquiries will be directed to us. For new groups, premium for COBRA continuants should be included with your initial premium check and sent to us.

Once the continuant is enrolled, we will take over billing and collection of premium. Any payments that may be collected for dental or vision products will be distributed back to you. You are responsible for remitting the monthly premium payment for any ancillary products to the appropriate carrier.

\* [We require you to utilize our COBRA administration services if you have less than 100 employees and are not using another third-party administrator for COBRA administration.](#) If you have more than 100 employees or use a third party administrator, you may waive the services provided you sign the appropriate indemnification form. Please contact your Sales Representative if you wish to pursue this option. Please contact the Florida Blue Continuation of Coverage Unit (CCU) at 855-509-1678 or [floridablue.com](http://floridablue.com).

#### Florida (Group size 19 or fewer eligible employees)

**If your group size is 19 or fewer eligible employees (for 50 percent or more of the previous calendar year),** Florida law requires you to comply with the Florida Health Insurance Coverage Continuation Act (FHICCA). It will be administered by us as well and cannot be waived. All questions regarding the FHICCA should be directed to the CCU at 855-509-1678. Premium for FHICCA continuants should not be remitted by the group. We will handle all billing and premium collection directly with the continuant.

#### Florida Blue COBRA Administration Services Save you Money

We will administer enrollment, billing and collection of payment for continuation coverage under COBRA and FHICCA for your group. This includes all Florida Blue and Truli for Health medical and Florida Blue vision plans offered by your company and Florida Combined Life branded Dental plans. We will not administer any other carrier products including CHP and FHCP plans.

## COBRA Employee Benefits Security Administration (EBSA) Guide:

EBSA Guide for Group Employers:

<https://www.dol.gov/ebsa/>

EBSA Frequently Asked Questions:

<https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>

### Time-Savers for You

Sign up for **EmployerPoint**, your Benefits Administration website. There are features such as **our enrollment tool** that allow you to enroll, change and/or terminate coverage for your employees and **View and Pay Invoice** which makes it easy to manage your monthly invoices. To get started, please complete and return the **Benefit Administrators Authorization** form available in the Employers section of [floridablue.com](http://floridablue.com) and [truliforhealth.com](http://truliforhealth.com)

After you've signed up for **EmployerPoint** and **our enrollment tool**, you can find links to training and job aids under the Training tab in EmployerPoint.

**EmployerPoint** allows you to view your COBRA continuant details for enrollment processed, general notices and election packets mailed.

### What your company is responsible for:

- General Notice of COBRA Rights: If your group does not use the Florida Blue enrollment tool, you will either have to notify us of requests to provide this notice to new enrollees or you can provide the notice directly to the enrollee. If you wish for us to provide the notice, use the contact information below. If you are providing the notice, a sample form is available on EmployerPoint.

**Note:** If you are using our enrollment tool there is no need to notify us. We will automatically send the General Notice of COBRA Rights.

- Qualifying Events: If your group does not use our enrollment tool you need to notify us of qualifying events and open enrollment changes within 30 days of the event to the contact information indicated below.

**Note:** If you are using our enrollment tool there is no need to notify us, we will automatically process the qualifying event election notices.

- Open Enrollment: It is your responsibility to provide Open Enrollment to your COBRA participants. We are responsible to offer Open Enrollment to the FHICCA participants. To report Open Enrollment participant selections use the contact information below.
- Payments for Fully-Insured Groups: You will be responsible for paying the Florida Blue vision and Florida Combined Life Dental COBRA premiums for the continuants. The payments may be submitted to the address on the invoice. We will collect these premiums on behalf of COBRA participants and refund them to you once the billing period is reconciled. You will not be responsible for paying the Florida Blue / Truli for Health, invoice for COBRA participants; we will bill them directly.
- Payments for Administrative Services Only (ASO) groups: You will be responsible for providing the monthly COBRA fully-insured rates to your Sales Representative. And, you will be responsible for paying the Florida Blue vision and Florida Combined Life Dental COBRA premiums for the continuants. The payments may be submitted to the address on the invoice. We will collect these premiums on behalf of COBRA participants and refund them to you once the billing period is reconciled. You will not be responsible for paying the Florida Blue Health invoice for COBRA participants. We will bill the COBRA participants and once the invoice is reconciled, we will refund your company the monthly premium less the ASO fee per contract per month.
- Annual Compliance Questionnaire: You will be responsible for responding to the Annual Compliance Questionnaire to ensure your group's compliance type is correct. The compliance type for the current calendar year is based upon the total average number of employees during the preceding calendar year. The questionnaire provides more information and is generally mailed in November of each year.

- Please contact your agent or Sales Representative if you have continuation questions about other carriers' products.
- COBRA Membership Take-Over Report is used to report COBRA membership activities.

If you chose another COBRA vendor or wish to self-administer COBRA, which is limited to group size over 100 employees, you will need to sign our indemnification waiver forms and return them to our office. Please contact your agent or Sales Representative for those forms.

If you are an employer subject to state FHICCA (fewer than 20 employees), you are only responsible for responding to the Annual Compliance Questionnaire. We will work directly with members who notify us that they would like to continue their coverage.

If you are an employer subject to federal COBRA (with 20 or more employees), you'll receive a call from our continuation coverage unit to verify your continuants information and set up a time to talk about COBRA with you one-on-one.

If you are not using our enrollment tool and need to report COBRA activities, please forward requests to [ContinuationOfCoverage@floridablue.com](mailto:ContinuationOfCoverage@floridablue.com). If your continuants have questions they may contact us at (855) 509-1678.

### COBRA Questions:

Group administrators please contact us at **1-866-946-2583** (Florida Blue) or **1-844-677-4822** (Truli for Health) and then enter your group number. Members with Continuation Coverage questions can contact us at 1-855-509-1678.

All returned checks (i.e., stop payment, closed account, insufficient funds, etc.) must be replaced by a Cashier's Check or Money Order immediately upon receipt of notification.

**Note:** During your renewal month, invoices are suppressed until the completion of the renewal or by the fifteenth day into the billing cycle.

If the rates on the invoice you receive at your renewal are not the correct rates, you must still submit payment for the amount listed "as billed" on that invoice. If it is determined that corrections need to be made, you will either receive a supplemental invoice for any additional premium due or a refund for any overpayment.

Please ensure you have access to the View & Pay Invoice tool to pay your invoice electronically. If you need to submit a paper check or money order, refer to the Contact Information section of this guide for the premium payment mailing address.

You should notify your Sales or Service Representative of any changes in your group's administration, address or telephone number.

If there are questions regarding rates during your renewal, please contact your Sales/Service Representative or Agent.

## COBRA Administration Waiver Approval Form (Form A)

### COBRA ADMINISTRATION WAIVER APPROVAL FORM (Form A)

GROUP NAME: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

# of Employees: \_\_\_\_\_ # of Florida Blue/Florida Blue HMO and/or Truli for Health Subscribers: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

REASON FOR REQUEST: (In Detail)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attached is the **ORIGINAL** waiver signed by the above referenced account. This account has met **both** of the requirements for declining Florida Blue and/or Truli for Health COBRA administration.

**Please select one below:**

- The account has over 100 eligible employees and has clearly demonstrated they have either an administrator or provided documentation of clear procedures for the administration of COBRA.
- The account is less than 100 eligible employees and utilizes a TPA to administer COBRA (Copy of contract is attached).

COBRA Administrator Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

\_\_\_\_\_  
Agent/Sales Representative \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Florida Blue and/or Truli for Health Continuation Coverage Representative \_\_\_\_\_ Date \_\_\_\_\_  
(Confirms that required documentation has been received)

Health and vision insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO and/or Truli for Health, which are affiliates of Florida Blue. Dental, Life and Disability are offered by Florida Combined Life Insurance Company, Inc., DBA Florida Combined Life, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

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## COBRA Administration Waiver Approval Form (Form C)

### COBRA ADMINISTRATION WAIVER APPROVAL FORM (Form C)

GROUP NAME: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

# of Eligible Employees: \_\_\_\_\_

# of Florida Blue/Florida Blue HMO and/or Truli for Health Covered Employees Subscribers: \_\_\_\_\_

\_\_\_\_\_ (Group Name) agrees to pay and be liable to Florida Blue, Florida Blue HMO, Truli for Health and any of their subsidiaries and affiliates (hereinafter collectively referred to as Florida Blue) and shall assume, indemnify, defend and hold harmless Florida Blue and/or Truli for Health from and against and in all respect of any and all losses, damages, liabilities, taxes, sanctions, interest and penalties, costs and expenses (including, without limitation, disbursements and reasonable legal fees incurred in connection therewith and in seeking indemnification therefore, and any amounts or expenses required to be paid or incurred in connection with any action, suit, proceeding, claim, appeal, demand, assessment or judgment) imposed upon, incurred by, or assessed against Florida Blue and/or Truli for Health and any of their employees arising by reason of or relating to any failure to comply with the continuation health care coverage requirements of section 162(k)/4980B of the Internal Revenue Code and sections 601 through 608 of ERISA which failure occurred with respect to any current, prior or future employee of \_\_\_\_\_ (Group Name) or any qualified beneficiary of such employee, as defined in section 162(k) (7)(B)/4980B(g)(1) of the Code. For purposes of this provision, references to the Internal Revenue code and ERISA shall include references to any provision of such statutes as they may be amended from time to time.

Group Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

By: \_\_\_\_\_

Signature (Type or Print): \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

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An Independent Licensee of the  
Blue Cross and Blue Shield Association



[floridablue.com](https://www.floridablue.com)

[truliforhealth.com](https://www.truliforhealth.com)

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