Capital Health PLAN℠
An Independent Licensee of the Blue Cross and Blue Shield Association

# ENROLLMENT APPLICATION

| 1. Election Type | Initial Enrollment (New Hire): ☐ | Open Enrollment: ☐ | Retiree: ☐ Retirement Date: - | Surviving Spouse: ☐ | Special Enrollment: ☐ * Please list the Qualifying Event and provide supporting documentation: |
|---|---|---|---|---|---|

| 2. SSN: | 3. Last Name: | 4. First Name: | 5. M.I.: |
|---|---|---|---|
| | | | |

**6. Physical Address:**

Street City State Zip Code County

**7. Mailing Address:** (If different from above)

Street City State Zip Code County

| 8. Date of Birth: | 9. Sex: ☐ Female ☐ Male | 10. Marital Status: ☐ Married ☐ Single ☐ Legally ☐ Widowed ☐ Divorced Separated | 11. Primary PH #: | 12. Work PH #: | 13. Other #: |
|---|---|---|---|---|---|
| | | | | | |

| 14. Name of Employer: | 15. Part-Time Hire Date: | 16. Full-Time Hire Date: | 17. Type of Employment: ☐ Full-Time ☐ Part-Time: _____ Hours per week |
|---|---|---|---|
| | | | |

**18. LIST ELIGIBLE FAMILY MEMBERS TO BE COVERED (PLEASE PRINT)**
A certified copy of the court order must be attached for dependents in court-ordered custody or guardianship of the certificate holder. If more space is required, attach a separate page with additional information. **Please provide (on the reverse side of this form) an alternate address for any dependent not living with you.**

**Applicant's Primary Care Physician Selection:**

**Current Patient?** ☐ Yes ☐ No

| 19. Relationship To You | 20. Sex | 21. Last Name, First Name MI | 22. SSN | 23. Date of Birth | 24. Disabled | 25. Dependent Primary Care Physician Selection(s): | 26. Current Patient? |
|---|---|---|---|---|---|---|---|
| Spouse | ☐ Male ☐ Female | | | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Dependent 1 Child Stepchild Other 🗐 | ☐ Male ☐ Female | | | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Dependent 2 Child Stepchild Other 🗐 | ☐ Male ☐ Female | | | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Dependent 3 Child Stepchild Other 🗐 | ☐ Male ☐ Female | | | | ☐ Yes ☐ No | | ☐ Yes ☐ No |

🗐 Supporting documentation required.

**27. Race/Ethnicity – Optional** (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

Employee: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Spouse: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Dependent 1: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Dependent 2: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Dependent 3: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other

**28. Are you or any member of your family (listed on this application) covered by any other health plan or health insurance that will be in effect concurrently with the coverage you are applying for?** ☐ Yes ☐ No
If yes, complete the appropriate section(s) below. If more space is needed, attach a separate sheet with additional information.

| OTHER HEALTH PLAN INSURANCE | | MEDICARE | |
|---|---|---|---|
| **Insured Member's Name:** **Date of Birth:** | | **Beneficiary Name:** | **Beneficiary Name:** |
| **Employment Status:** ☐ Active ☐ Retired **Name of Employer:** _____ **Type of coverage:** ☐ Single ☐ Family | | **Entitlement Reason:** Age 65 or Older ☐ End Stage Renal Disease ☐ Other Disability | **Entitlement Reason:** Age 65 or Older ☐ End Stage Renal Disease ☐ Other Disability |
| **Policy #:** **Effective Date:** | | **Medicare HIC#/MBI:** | **Medicare HIC#/MBI:** |
| **Name of Insurance Company:** **Phone:** | | **Part A Effective Date:** | **Part A Effective Date:** |
| Does the above insurance cover "all" family members including yourself? ☐ Yes ☐ No **If no**, please list dependents not covered on a separate sheet. | | **Part B Effective Date:** | **Part B Effective Date:** |

**29. ACCEPTANCE OF COVERAGE/MEMBERSHIP:**
I have read and understand the Acceptance of Any Coverage/Membership on the reverse side of this form.

**Signature of Applicant/Employee**: Date:

| Authorized Group Administrator's Signature: | Date: | Group ID: | Employee's Proposed Coverage Effective Date: |
|---|---|---|---|
| | | | |
| **Authorized Group Administrator's Printed Name:** | **Group Administrator's Contact Phone #:** | | **Group Administrator Email Address:** |
| | | | |

**Please return this completed form by:**
**Mail:** Capital Health Plan*Attn: Enrollment*PO Box 15349*Tallahassee FL 32317 **Fax:** 850-523-7369 **OR** **Email:** Enrollment@chp.org

ACCEPTANCE OF ANY COVERAGE/MEMBERSHIP –
**READ BEFORE SIGNING ON THE FRONT OF THIS FORM**

I hereby apply for the coverage/membership selected on the front side of this form. My employer has selected the coverage/membership through Capital Health Plan, Inc., d/b/a/ Capital Health Plan (CHP). 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 of the requirements of the group contract.
2. If my dependents' coverage/membership, if any, is to be issued and continued, my dependents must meet all of the requirements of the group contract.
3. If I must pay part or all of the premium, coverage/membership shall not become effective until CHP accepts this application and assigns an effective date.

I agree that any controversy or dispute between CHP and myself or my dependents shall be subject to the complaint and grievance procedures, including binding arbitration, set forth in the CHP Member Handbook.

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

I authorize persons or entities that have any medical or other records or knowledge of me or my eligible dependents to release that information to CHP. These persons or entities include any: 1) licensed physician; 2) medical practitioner; 3) hospital; 4) clinic or other medical or medically related provider; 5) insurer; 6) employer; or, 7) other organization, institution, or person. This information also may be released to any affiliated or reinsurance carrier. I also authorize CHP, at its sole discretion and consistent with law, to use and disclose financial and health information obtained about me and/or my eligible family members for treatment, payment, and/or health care operations purposes, including coordination of benefits, if needed. This routine consent covers future, known, or routine needs for personal health information. These routine needs include treatment, coordination of care, quality measurement, including surveys of members, accreditation, and billing. These releases specifically include, but are not limited to, authorization to release: 1) any and all medical records; and, 2) information about, associated with, or with reference to certain conditions. This information consists of specific medical information on me or my dependents, including, but not limited to, authorization to release: 1) any and all medical records; and, 2) information about certain conditions. These conditions include: 1) exposure to HIV infection; 2) ARC; 3) alcohol or drug dependency; and, 4) mental and nervous disorders. I understand that CHP shares no member-identifiable information with employers unless the member provides specific consent.

When an overpayment is made, I authorize CHP to recover the excess from any person or entity that received it.

I acknowledge that, if I apply for CHP coverage/membership at a later date, coverage/membership may not be available until the next open enrollment. Also, I may be required to furnish evidence of insurability.

I acknowledge that CHP coverage/membership is contingent on the complete, accurate disclosure of the information requested on this form. I represent that the statements on this application are true and complete. I understand and agree that any misstatements or omissions may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the terms and conditions of the group contract. I understand that this application is part of the group contract.

**DEPENDENT'S ALTERNATE ADDRESS INFORMATION:**

| NAME | ALTERNATE ADDRESS |
|---|---|
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**FRAUD WARNING**

**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.**