Florida Blue
In the pursuit of health

ACA Change Application

Add due to newly married or eligible domestic partner and/or dependents

Return to: Florida Blue
P.O.Box 45074
Jacksonville, FL 32232

I hereby request the following changes(s).
A new application must be completed when changing plans.

Part 1 (Required)

CURRENT POLICY HOLDER'S NAME (Last, First, Middle Initial)		PLAN NUMBER	POLICY NUMBER
STREET ADDRESS (Include Apartment #)			COUNTY
CITY			STATE / ZIP +4
(AREA CODE) TELEPHONE NUMBER	DATE OF BIRTH (Month / Day / Year)	AGE	SEX ☐ MALE ☐ FEMALE

Part 2

List All eligible dependent(s) to be added to policy based on this change. (Attach marriage certificate)

FIRST NAME AND MIDDLE INITIAL (Include last name if different from policy holder)	SOCIAL SECURITY # (N/A for newborns.)	DATE OF BIRTH Mo. / Day / Yr.	AGE	RELATION TO ME	ZIP
1. Policy Holder	Above	Above		Self	
2.				☐ Spouse ☐ Domestic Partner	
3.				☐ Son ☐ Daughter ☐ Other	
4.				☐ Son ☐ Daughter ☐ Other	

Part 3

☐ **For plans without a P or V Variation ID.** By checking this box I understand that this plan does not offer coverage for pediatric dental services. Pediatric dental coverage is available and can be purchased as a stand-alone product. I certify that if individuals under the age of 19 are enrolled in this plan they are also enrolled in an Exchange certified stand-alone pediatric dental plan. I agree to notify Florida Blue/Florida Blue HMO immediately if such pediatric dental coverage is terminated.

Has the Applicant, or Spouse/Domestic Partner, or any dependent age 18 or older used tobacco in any form (e.g., cigarettes, cigars, pipes, snuff or chewing tobacco) regularly four or more times per week on average, excluding religious or ceremonial uses, in the past six months? ☐ Yes ☐ No If "Yes", please identify person and date of last use:

_____ _____
Name Last Date of Use

I understand that the above change for dependent(s) is for marriage or newly eligible domestic partner, and that the policy's effective date of coverage is on the first day of the following month after the application is submitted. Please provide the event date of this change below. **Note:** submission must be within 60 days of event date for consideration.

Event Date for change:_____

Part 4

NAME CHANGE ***(If requested as part of change)***

CHANGE NAME FROM: _____ TO: _____

INDICATE REASON FOR NAME CHANGE: ☐ MARRIAGE

SIGNATURE (Reqd)

I hereby request the changes indicated above to my policy. I understand and agree that the changes will not be effective until the Change Application is accepted and the initial rate is paid. I declare that all statements made are true and complete. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurer, or files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

By making the request to add the dependent(s) above you represent you meet the eligibility criteria for a special enrollment period and the information provided is accurate and complete. Florida Blue/Florida Blue HMO may request additional documentation to confirm whether you qualify for a special enrollment period.

X _____ _____
POLICY HOLDER'S SIGNATURE (REQUIRED) DATE OF CHANGE APPLICATION

The Summary of Benefits and Coverage (SBC) is available at floridablue.com. A paper copy is also available, by calling 1-800-352-2583. TTY/TDD dial 1-800-955-8771.
Health insurance if offered by Blue Cross and Blue Shield of Florida, Inc., d/b/a Florida Blue and HMO coverage is offered by Health Options, Inc., d/b/a Florida Blue HMO, an affiliate of Florida Blue.
Both companies are Independent Licensees of the Blue Cross and Blue Shield Association.
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