Florida Combined Life

An Independent Licensee of the
Blue Cross and Blue Shield Association

Employee Change Form for Self Insured Plans

We can help

If you, or someone you're helping, has questions about Florida Combined Life dental plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-888-223-4892.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Florida Combined Life dental plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-223-4892.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Florida Combined Life dental plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-888-223-4892.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Florida Combined Life dental plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-888-223-4892.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Florida Combined Life dental plans, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-888-223-4892.

如果您，或是您正在協助的對象，有關於 插入項目的名稱 Florida Combined Life dental plans ,方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 1-888-223-4892。

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Florida Combined Life dental plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-888-223-4892.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Florida Combined Life dental plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-223-4892.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Florida Combined Life dental plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-888-223-4892.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Florida Combined Life dental plans ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-888-223-4892.

Se tu o qualcuno che stai aiutando avete domande su Florida Combined Life dental plans, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-888-223-4892.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Florida Combined Life dental plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-223-4892 an.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Florida Combined Life dental plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-223-4892 로 전화하십시오.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Florida Combined Life dental plans, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-888-223-4892.

જો તમે કે તમે મદદ કરી રહ્યાં હો તેમને Florida Combined Life dental plans વિશે પ્રશ્નો હોય, તો તમને મદદ અને તમારી ભાષામાં માહિતી કોઇ ખર્ચ વગર મેળવવાનો અધિકાર છે. દુભાષિયા માટે આ નંબર પર ફોન કરો, 1-888-223-4892.

หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคาถามเกี่ยวกับ Florida Combined Life dental plans,
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-888-223-4892

1557 Non-Discrimination

Florida Combined Life Insurance Company, Inc. (FCL) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. FCL does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

FCL.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact 1-888-223-4892

If you believe that FCL has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
Email civilrightscoordinator@fclife.com.

You can file a grievance in person or by mail, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at:

U.S. Department of Health and Human
Services, 200 Independence Avenue SW.,
Room 509F, HHH Building, Washington, DC 20201
1–800–368–1019, 800–537–7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

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Mail to:
Membership Services
P. O. Box 44144
Jacksonville, FL 32221
Fax No. 904-997-5471

Employee Change Form for Self Insured Plans

CHECK THOSE THAT APPLY AND COMPLETE THE LINES INDICATED:	**Lines**
☐ Name change	1A, 1B, 2A, 18
☐ Social Security Number correction	1A, 2A, 2B, 18
☐ Add spouse	1A, 2A, 3-16, 18
☐ Add domestic partner (DP)	1A, 2A, 3-16, 18
☐ Add child (ren)	1A, 2A, 3-16, 18
☐ Add child (ren) of DP	1A, 2A, 3-16, 18
☐ Terminate spouse	1A, 2A, 3-6, 9, 16, 18
☐ Terminate domestic partner (DP)	1A, 2A, 3-6, 9, 16, 18
☐ Terminate child (ren)	1A, 2A, 3-6, 9, 16, 18
☐ Terminate child (ren) of DP	1A, 2A, 3-6, 9, 16, 18
☐ Terminate all coverage	1A, 2A, 3, 18
☐ Address change	1A, 2A, 3, 18
☐ Other Dental Insurance	1A, 2A, 17, 18
☐ Other _____	

FOR EMPLOYER USE: (Required Information)

GROUP NUMBER: _____

GROUP NAME: _____

EFFECTIVE DATE: _____

PLAN TYPE: _____

REMARKS: _____

1A	EMPLOYEE Last Name First Name Middle Initial	1B	Previous name (if this is a Name Change)
2A	Social Security Number	2B	Correct Social Security Number
3	Street City State Zip Phone		

List All Eligible Dependents To Be Covered. Children of a domestic partner may be covered when the domestic partner is also covered. Attach additional sheet of paper, if necessary. Sign and date it. Check all that apply.

4 Last Name, First Name, M.I. *(Please provide information in the corresponding numbered spaces below.)* / 5 Social Security Number (Please provide in spaces below.)	6 Relation to You (DP = Domestic Partner)	7 Marital Status: Married	7 Marital Status: Unmarried No Children	8 Gender (M/F)	9 Birthdate mm/dd/yyyy	10 Disabled	11 Lives with You	12 You Support Financially	13 Student FT/PT	14 Florida Resident	15 Covered by Medicaid
4 / 5	☐ Spouse *or* ☐ DP										
4 / 5 ___ - ___ - ____	☐ Child *or* ☐ DP Child	☐	☐			☐	☐	☐	☐	☐	☐
4 / 5 ___ - ___ - ____	☐ Child *or* ☐ DP Child	☐	☐			☐	☐	☐	☐	☐	☐
4 / 5 ___ - ___ - ____	☐ Child *or* ☐ DP Child	☐	☐			☐	☐	☐	☐	☐	☐

16 Reason: ☐ Marriage ☐ Divorce ☐ Age Limit ☐ Employment Termination ☐ Other

17 Do you or any of your dependents have other Dental insurance under a group plan? ☐ Yes ☐ No
If "Yes," complete the following sections:

Name of Person	Group Plan	Policy Number	Insurance Company and Address

18 Membership granted to persons hereon shall be subject to all provisions and limitations of the group agreement. I am aware that a change in dependents may affect the amount deducted from any wages (if any) for Florida Combined Life Dental Plan coverage, and I hereby authorize such a change.

_____ Employee Signature

_____ Date Signed

Copies to: Membership Services, Employer