Florida Blue
In the pursuit of health®

PPO–Eligible Dependent Application For Continuous Coverage

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE APPLICANT FOR CONTINUOUS COVERAGE:

Name: Social Security Number:

LAST FIRST MIDDLE INITIAL

Street Address: Include Apartment Number:

City: State: Zip+ 4: County:

Date of Birth:(month/day/year) Age: Sex: ☐ Female ☐ Male

LIST ANY DEPENDENTS TO BE ISSUED CONTINUOUS COVERAGE ALONG WITH MAIN APPLICANT:

First Name and Middle Initial (Include last name if different from policy holder.)	Social Security#	Date of Birth (month/day/year)	Age	Relation to Member	Zip
1.					
2.					
3.					
4.					

RECEIVING CONTINUOUS COVERAGE FROM:

Check one: ☐ Parent's Policy or ☐ Spouse's Policy

Policy Holders' Name: Policy Number:

LAST FIRST MIDDLE INITIAL

X

Applicant's Signature *Date of Application*

The Summary of Benefits and Coverage (SBC) is available online at **floridablue.com.** If you are unable to locate your SBC on the website, or wish to have a SBC sent to you, call 1-800-352-2583. TTY/TDD dial 1-800-955-8771.

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