

# Health First Health Plans

## Large group application



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www.health-first.org

For health plan use only	
Group number	Division number

### I. Group information

Legal name of applicant \_\_\_\_\_ Date business established \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Federal identification number \_\_\_\_\_ Nature of business \_\_\_\_\_

Legal status:  Corporation  Partnership  Sole Proprietorship  Other \_\_\_\_\_

Contact person \_\_\_\_\_ Title \_\_\_\_\_ E-mail \_\_\_\_\_

Billing address (street/PO box) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Zip \_\_\_\_\_

Are there any affiliates or subsidiaries to be covered?  No  Yes (list) \_\_\_\_\_

Will this coverage be replacing any existing or previously in force group plan?  No  Yes If yes:

Effective date \_\_\_\_\_ Termination date \_\_\_\_\_ Carrier \_\_\_\_\_ Group number \_\_\_\_\_

Workers compensation carrier \_\_\_\_\_ Policy number \_\_\_\_\_

Billing option:  Standard method  Wash method Grace period:  Standard (10 days)  Extended (for add'l premium)

### II. Eligibility/participation

- HMO employer contribution \_\_\_\_\_ per employee \_\_\_\_\_ per dependents  
POS employer contribution \_\_\_\_\_ per employee \_\_\_\_\_ per dependents
- Waiting period (Check one and indicate time frame, 180-day maximum waiting period):  
 Day following \_\_\_\_ days; or  First of the month following \_\_\_\_ days or \_\_\_\_ months  Date of hire  
Waive for initial enrollment?  Yes  No
- Does eligible employee include (check all that apply):  
 Full time employees working \_\_\_\_ hours/week  Retirees  Other (explain) \_\_\_\_\_
- Are any present or former employees or dependents currently on or eligible to elect continuation of coverage (COBRA)?  
 No  Yes If yes, please list their names, dates they started continuation and the qualifying event:  
\_\_\_\_\_
- Does a formal Leave of Absence policy exist providing for continued coverage while on leave (other than FMLA)?  
 Yes  No
- Are any employees currently on Leave of Absence?  No  Yes  
If YES, please list their names, date leave began, and type of leave: \_\_\_\_\_
- Do you currently administer a Section 125 Plan?  Yes  No

8. Please fill in the number of employees in each category:

On the payroll	Full-time employees	Part-time employees	In waiting period	Total # electing HFHP coverage (incl. COBRA beneficiaries)	Declining with no other group coverage	Declining with other group coverage

**III. Plan selection – Please select plan and options**

HMO: plan option: \_\_\_\_\_ Prescription drug rider option: \_\_\_\_\_ Vision rider option: \_\_\_\_\_

POS: plan option: \_\_\_\_\_ Prescription drug rider option: \_\_\_\_\_ Vision rider option: \_\_\_\_\_

**IV. Other required information (answer according to the best of your knowledge)**

1. Has anyone had a claim over \$10,000 in the past two years?  No  Yes If yes, list details below:

Name	Date of birth	Diagnosis	Occurrence date	Claims paid	Prognosis

2. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 12 months?  Yes  No

3. Does anyone have a continuing claim for an existing mental or physical disorder?  Yes  No

4. Has anyone been advised to have surgery in the last six months or anticipate hospitalization for any other reason?  Yes  No

5. Are there any spouses or dependents who are not actively at work performing his or her duties full time due to illness or injury?  Yes  No

If you answered yes to any of the above questions, please provide details below:

Are there any handicapped dependents over the limiting age to be covered in the group?  Yes  No

If yes, are the handicapped dependents currently insured by the current group plan?  Yes  No  
(If YES, please provide the name of the employee, dependent name, statement of disability/diagnosis from attending physician.)

\_\_\_\_\_

\_\_\_\_\_

**V. Broker information**

AGENT OF RECORD – Party(s) to receive commissions, production credit, correspondence and to whom income will be reported:

Agent/broker name \_\_\_\_\_ Tax ID/SS# \_\_\_\_\_

Agency name \_\_\_\_\_ Telephone number \_\_\_\_\_ Fax \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Zip \_\_\_\_\_

**VI. Applicant certification**

Applicant certifies that the information provided is complete and accurate to the best of applicant’s knowledge. Applicant understands that any material misrepresentation or material omission contained herein may be used to void the contract. Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree (under Florida Law Chapter 95-340). Applicant shall notify the plan promptly of any changes in this information that may affect the eligibility of employees or their dependents. It is understood and agreed that coverage will be effective only on the date specified by the plan after the application has been approved by the plan and a full first month’s premium is received.

Applicant’s signature	Applicant’s title	Date
Soliciting agent’s signature	Requested effective date	Premium amount received

1. ELIGIBLE EMPLOYEES are generally those employees working full-time, having a normal work week of 30 or more hours (unless indicated otherwise on group application) and who have met the applicable waiting period requirements. Temporary, or substitute employees are not eligible for coverage. Independent contractors are eligible if the applicant contributes toward the coverage and the minimum participation requirements are met when all independent contractors are offered coverage.
2. APPLICANT is required to contribute a minimum of 50% of the employee only premium.
3. IF THE APPLICANT pays 100% of the premium, all eligible employees must be insured. If the applicant pays less than 100% of the premium, 75% of the eligible employees must be insured.
4. APPLICANT agrees to furnish all data necessary for the efficient administration of the group coverage provided for the covered employees and dependents, if any, to the plan.
5. APPLICANT agrees that the broker/agent listed on this application is a licensed agent in the State of Florida to whom commissions will be paid and will service the group.