

Health First Health Plans

Small group application



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For health plan use only

Group number	Division number
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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 _____ 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 _____

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. Standard and basic options have 90-day maximum waiting period, all others have maximum 180-day waiting period):
 First of the month following _____ Day following _____ days Date of hire Waive
- Do eligible employees include (check all that apply):
 Full time employees Leased 1099s (requires 1096) Other (explain) _____
- Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the health plan is primary and Medicare is secondary. For your group: Medicare is primary HFHP is primary
- Under federal law, if your group had 20 or more employees on your payroll and at least 50% of the employer's working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had fewer than 20 employees, you must provide state continuation. You offer: COBRA State continuation
- Are any present or former employees or dependents currently on or eligible to elect continuation of coverage (COBRA or FHCICA)? No Yes If yes, please list their names, dates they started continuation and qualifying event:

- Please fill in the number of employees in each category:

Total # of employees	Employees working 25+ hours/week	Part-time employees	In waiting period	Electing HFHP coverage	Electing COBRA/FHCICA	Declining with no other group coverage	Declining with other group coverage

III. Plan selection – Please select plan and option(s)

Plan option 1: _____ Prescription drug rider option: _____ Vision rider option: _____
 Plan option 2: _____ Prescription drug rider option: _____ Vision rider option: _____

Standard plan Accept (option ____) Reject State-mandated mental/nervous rider Accept Reject
 Basic plan Accept (option ____) Reject State-mandated substance abuse rider Accept Reject
 High-deductible health plan Accept Reject

(Florida state laws require small employer carriers to offer standard, basic, and high deductible plans. The applicant certifies he/she has been offered these plans and has made an election above.)

IV. Other required information

Are there any handicapped dependents over the limiting age to be covered in the group? Yes No
 (If yes, please provide the name of the employee, dependent name, statement of disability/diagnosis from attending physician.)

If yes, are the handicapped dependents currently insured by the current group plan? Yes No

Are all employees covered by workers' compensation? Yes No

Name of workers' comp carrier _____ Policy number _____

If no, list all employees not covered and reason:

Name _____ Title (owner, partner, officer, etc.) Reason not covered _____

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 _____ 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 those employees working full-time (25 hours per week) 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. For groups of 5 or less, if the applicant pays less than 100% of the premium, 100% of the eligible employees must be insured. For groups of 6 or more, 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.