AdventHealth
Advantage Plans
Underwritten by Health First Commercial Plans

Enrollment/Change Form

For large employer groups

Please print using black ink. Initial all corrections.
All questions must be answered.

This section to be completed by Benefit Administrator:

Company Name: _____ Initial Enrollment _____ Waiving Coverage ____
Group #: _____ Open Enrollment _____ *Complete Section 5*
Division #: _____ COBRA _____ Qualifying Event ____
Date of Hire/Termination: _____ Effective Date: _____ *Complete Section 6*

Section 1. Type of Transaction *(Check all that apply)*

__Enrollment: __Employee __Retiree __Spouse __Child(ren)

__Change: __Name __Address __Plan __Division __Coverage __Termination __Dependent Termination

Section 2. Employee Information

*(Must attach copy of supporting documentation if dependent has a different last name than the employee. See **Supporting Documentation**, section 6)*

Applicant SSN / Member ID:	First Name:		M.I.	Last Name:	
Home Address:	Apt. #:	City:		State:	Zip:
Mailing Address (if different than above):	Apt. #:	City:		State:	Zip:
Phone #:	Cell Phone #:	Email Address:		Ethnicity	
Date of Birth (mm/dd/yyyy):	Sex: Male Female	Plan Name:		Occupation:	
Subscriber's PCP (first, last name):					

Section 3. Enrollment / Change Information

*(Must attach copy of supporting documentation for qualifying event. See **Supporting Documentation**, section 6)*

Change Type: (A=Add, C=Change, T=Termination)	***First Name***	***M.I.***	***Last Name***	***Relationship to Applicant***	***Social Security #***	***Sex M/F***	***Date of Birth***	***Dependent's PCP (first, last name***
A/C/T						M/F		
A/C/T						M/F		
A/C/T						M/F		
A/C/T						M/F		

1) Does any dependent listed above have a permanent residence different than the applicant? ___Yes ___No
If yes, provide name of dependent and address: _____

2) Does any dependent child listed above have a permanent physical or mental handicap? ___Yes ___No
If yes, provide name of dependent and age when the handicap was diagnosed: _____

Section 4. Other Coverage Information (if applicable)

Complete this section only if you or any of your dependents have other health coverage that will not be cancelled when the coverage under this application becomes effective. List names of each individual covered. If you and/or your dependents will not have other coverage, please initial _____.
I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. Initial_____

Group Coverage __Yes __No	Name and Address of Other Insurance Carrier
Effective Date (MM/DD/YYYY)	Type of Policy __Employee Only __Employee/Spouse __Employee/Child(ren) __Family
Name of Policyholder (First, Last)	Birth Date (MM/DD/YYYY) __Male __Female
Relationship to Applicant __Self __Spouse __Dependent	Employer's Name / Employment Start Date (MM/DD/YYYY)
Group Number	Policy Number

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name & Date of Birth of policyholder for other coverage
Spouse Name:				
Dependent Name:	B/S/F			
Dependent Name:	B/S/F			
Dependent Name:	B/S/F			

*B. Enter 'B" when this dependent is covered under both you and your spouse's insurance plan (married).
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Section 5. Waive Coverage (if applicable)

Medical coverage

I am Refusing all Health Coverage at this time. I understand that if I decide to apply later coverage may not be available until the next open or special enrollment period. Signature:_____ Date:_____

___I am declining coverage for: __Myself ___Spouse __Child(ren) *(check all that apply)*

Reason for declining coverage: __Other coverage ___Medicare __TriCare __No coverage
(check all that apply and provide copy of ID card)

Section 6. Qualifying Event (if applicable)

Event date: _____ Qualifying event: _____ Documentation attached? ___Yes ___No

Supporting documentation *is showing evidence of his/her dependent status (birth certificate, court order for guardianship, marriage certificate, adoption papers, etc.) for either qualifying event or if adding a dependent with a different last name than that of the employee. Must attach copy for coverage.*

Section 7. Attestation

Coverage Terms:

I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer applications have been accepted and approved by AdventHealth Advantage Plans. I hereby elect the above enrollment or change to my enrollment with AdventHealth

Advantage Plans. I authorize my employer to deduct from my earnings my share of the payment for coverage and to make any necessary payments to the plan. I understand that my coverage/membership is to be issued and continued on the basis that I and any dependents covered under this coverage/membership, must meet all of the requirements of my plan.

I am aware and understand that membership granted to persons herein shall be subject to all provisions and limitations of the group contract. I am aware that a change in coverage of dependents may affect the amount deducted from my paycheck for these benefits, and I hereby authorize any such change.

If I am in a high-deductible health plan designated for use with a Health Savings Account (HSA) under Internal Revenue Service Code section 223, I recognize and authorize AdventHealth Advantage Plans to exchange certain limited information obtained from this application with its preferred financial partner(s) for the purposes of initial enrollment in, and administration of, HSAs.

I understand that if I am in a HSA qualified High Deductible Health Plan and I elect to receive Prior Carrier Credit under Florida law, my plan may no longer qualify as an HSA compatible plan.

General Terms:

1. *I agree that in the event of any controversy or dispute between AdventHealth Advantage Plans I and my dependents must exhaust the appeal and/or grievance processes in the Certificate of Coverage issued to me.*
2. *When an overpayment is made, I authorize AdventHealth Advantage Plans to recover the excess from any person or entity that received it.*
3. *I acknowledge that, if I apply for AdventHealth Advantage Plans coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period.*
4. *I understand and agree that this Enrollment/Change Request form may be transmitted to AdventHealth Advantage Plans or its agent by my employer. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers"), including pharmacies or pharmacy database benefit managers to give to AdventHealth Advantage Plans or its agent information concerning the medical history, medical records (may contain HIV/AIDS, psychiatric and/or chemical dependency treatment information), prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health and substance abuse. I further authorize AdventHealth Advantage Plans to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. The plan agrees to comply with all HIPAA privacy regulations. I have discussed the terms of this authorization with those affected by this Enrollment/Change Request form, and I have obtained their consent to those terms. I understand I may cancel this authorization in writing to the plan and unless revoked this authorization will remain valid for the terms of the coverage and for so long as thereafter allowed by law.*
5. *I understand that my employer is not an agent of Health First Commercial Plans, Inc. I also understand that my employer is responsible for notifying all employees of: 1. Effective dates; 2. All termination dates; 3. Any conversion, COBRA or ERISA rights or responsibilities; and 4. All other matters pertaining to coverage/membership under the group contract.*

To the best of my knowledge and belief, I represent that all information supplied in this form is true and complete. On behalf of myself and the eligible persons listed herein, I acknowledge that I have read and understand this form in its entirety. I understand that in the event that I fail to sign this form after the above transaction request or for any reason AdventHealth Advantage Plans does not receive notice of the above transaction request within a reasonable time following the event, mine and my dependents' eligibility may be affected.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

EMPLOYEE SIGNATURE *DATE*

AdventHealth Advantage Plans is underwritten by Health First Commercial Plans, Inc. Health First Commercial Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations. AdventHealth Advantage Plans agrees never to see your information. By submitting your email address, you expressly agree to receive promotional information from AdventHealth Advantage Plans, subcontractors and their affiliates regarding information, events, promotions, specials and patient satisfaction surveys. You also understand that you have the right to "opt out" at any time through request in a reply to the email

AdventHealth Advantage Plans

Underwritten by Health First Commercial Plans

Nondiscrimination Notice

AdventHealth Advantage Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AdventHealth Advantage Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AdventHealth Advantage Plans:

- 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, accessible electronic 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, please contact our Civil Rights Coordinator.

If you believe that AdventHealth Advantage Plans 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, 6450 US Highway 1, Rockledge, FL 32955, 321-434-4521, 1-800-955-8771 (TTY), Fax: 321-434-4362, civilrightscoordinator@hf.org. You can file a grievance in person or by mail, fax, 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*.

AdventHealth Advantage Plans is underwritten by Health First Commercial Plans, Inc. Health First Commercial Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

AdventHealth
Advantage Plans
Underwritten by Health First Commercial Plans

English:
This Notice has Important Information. This notice has important information about your application or coverage through AdventHealth Advantage Plans. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 844-522-5279.

Spanish:
Este Aviso contiene información importante. Este aviso contiene información importante acerca de la solicitud o cobertura que usted tiene con AdventHealth Advantage Plans. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 844-522-5279.

Haitian Creole:
Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a gen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè AdventHealth Advantage Plans. Chèche dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 844-522-5279.

Vietnamese:
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc hợp đồng bảo hiểm qua chương trình AdventHealth Advantage Plans của Quý vị. Xin xem các ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 844-522-5279.

Portuguese:
Este aviso contém informações importantes. Este aviso contém informações importantes a respeito da sua solicitação ou cobertura por meio dos AdventHealth Advantage Plans. Consulte datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter a sua cobertura de plano de saúde ou ajuda com custos. Você tem o direito de obter estas informações e ajuda no seu idioma e sem custos. Ligue para 844-522-5279.

Chinese:
本通知包含重要的資訊。本通知包含關於您透過 AdventHealth Advantage Plans 提交的申請或保險的重要資訊。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或費用補貼。您有權以您的母語免費取得本資訊及幫助。請撥電話 844-522-5279。

French:
Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire AdventHealth Advantage Plans. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 844-522-5279.

Tagalog:
Ang Paunawa na ito ay naglalaman ng Mahalagang Impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagkakasaklaw sa AdventHealth Advantage Plans. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan kang magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagkakasaklaw sa kalusugan o makatulong sa mga gastusin. May karapatan kang makuha ang impormasyon at tulong na ito sa iyong wika nang libre. Tumawag sa 844-522-5279.

Russian:
Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через AdventHealth Advantage Plans. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 844-522-5279.

Arabic:
يحوي هذا الإشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال AdventHealth Advantage Plans. ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التغطية الصحية أو للمساعدة في دفع التكاليف. لك الحق في الحصول على معلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بالرقم 844-522-5279.

Italian:
Questo avviso contiene informazioni importanti. Questo avviso contiene informazioni importanti sulla sua domanda o copertura attraverso AdventHealth Advantage Plans. Cerchi le date chiave in questo avviso. Potrebbe essere necessario un suo intervento entro una scadenza determinata per consentirle di mantenere la sua copertura o sovvenzione. Ha il diritto di ottenere queste informazioni e assistenza nella sua lingua gratuitamente. Chiami il numero 844-522-5279.

German:
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch AdventHealth Advantage Plans. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Anspruch auf Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 844-522-5279.

Korean:
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 AdventHealth Advantage Plans를 통한 보장에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 확인하십시오. 귀하는 건강 보장을 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 844-522-5279로 전화하십시오.

Polish:
Niniejsze ogłoszenie zawiera ważne informacje. Niniejsze ogłoszenie zawiera ważne informacje dotyczące Państwa wniosku lub zakresu świadczeń realizowanych poprzez AdventHealth Advantage Plans. Może zaistnieć potrzeba podjęcia przez Państwa pewnych działań w określonym terminie w celu zachowania ubezpieczenia zdrowotnego lub otrzymania pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnego uzyskania informacji i pomocy w języku ojczystym. Prosimy zadzwonić pod numer 844-522-5279.

Gujarati:
આ સૂચનામાં અગત્યની માહિતી છે. આ સૂચનામાં ફ્લોરિડા હોસ્પિટલ કેર એડવાંટેજ દ્વારા તમારી અરજી અથવા કવરેજ વિશેની અગત્યની માહિતી છે. આ સૂચનામાંની ખાસ તારીખો જુઓ. તમારા આરોગ્ય કવરેજને જાળવી રાખવા અથવા ખર્ચ અંગે મદદ મેળવવા માટે ચોક્કસ સમયમર્યાદા સુધીમાં તમારે કાર્યવાહી કરવાની જરૂર પડી શકે છે. તમને આ માહિતી અને મદદ તમારી ભાષામાં વિના મૂલ્યે મેળવવાનો અધિકાર છે. 844-522-5279 પર કૉલ કરો.

Thai:
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการสมัครหรือขอบเขตการประกันสุขภาพของคุณผ่าน AdventHealth Advantage Plans โปรดดูกำหนดการสำคัญในประกาศนี้
คุณอาจจะต้องดำเนินการภายในเวลาที่กำหนดเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย
คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 844-522-5279.