6450 US Highway 1, Rockledge, Florida 32955
Toll-free 844.552.5279
AdventHealthAdvantagePlans.com

Large Group Application

For AdventHealth Advantage Plans use only:

Group number	Division number

1. Group Information

Legal name of applicant________________________ Date business established ______________

Doing Business As (DBA) ______________________Total number of employees ______________

Street address ____

City________________________ State________ County______________ Zip ______________

Telephone_______________ Fax________________ E-mail ________________________

Does your company have additional locations? ___Yes ___No

If yes, where? ____

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: ____________________

Workers compensation carrier ____________________ Policy number ____________________

2. Eligibility/Participation

1. HMO employer contribution __________ per employee _________ per dependents
   POS employer contribution __________ per employee _________ per dependents

2. Waiting period (Check one and indicate time frame, 90-day maximum waiting period):
   __First of the month following _____days, or
   __Day following _____ days, or
   __Date of hire

3. Waive for initial enrollment? __Yes __No

4. Does coverage end for terminated employees or employees no longer eligible for benefits,
   ___on the date of termination ___on the last day of the month in which they are terminated

5. Are employees who are terminated or laid off and then re-hired required to meet the waiting period again? ___Yes ___No
   If no, what is the maximum time of separation (6 months maximum)? ____________________
   What will their effective date be?____

6. Do employees going from a non-eligible status to an eligible status who have been employed for the length of the waiting period, have to meet the waiting period before becoming eligible to enroll in the health plan? ___Yes ___No

7. Does "eligible employee" include (check all that apply): __Full time employees working ____ hours/week __Part time __Retirees __Other (explain): ____________________

8. Are any present or former employees or dependents currently on COBRA under your group plan?
__No __Yes *If yes, please list their names, dates they started COBRA and the qualifying event:*
____
____
____

9. Who is your COBRA administrator? ____________________

10. Does a formal Leave of Absence policy exist providing for continued coverage while on leave (other than FMLA)? __Yes __No
Please attach your leave policy: ____________________

11. Are any employees currently on Leave of Absence? ___No ___Yes
If yes, please list their names, date leave began, and type of leave: ____________________
____

12. Are employees considered "employees" while on leave? ___Yes ___No

13. Does the company continue to contribute to the employee's health premium while the employee is on leave? ___Yes ___No

14. Do you currently administer a Section 125 Plan? ___Yes ___No

3. Plan Selection

___HMO ___POS Plan option:____________________

___HMO ___POS Plan option:____________________

___HMO ___POS Plan option:____________________

4. 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? __Yes __No

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 seek any additional treatment for an existing condition?
__Yes __No

5. Are there any employees or dependents who are not actively at work performing his or her duties full time due to illness or injury?
__Yes __No

6. 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 names of the employee and dependent(s), and attach a statement of disability/diagnosis from physician.

If you answered yes to questions 1-6, please provide details below:
____
____
____

5. Broker Information

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

Agent/Broker name ______________________ Tax ID/SS# ______________________

Agency name______________________ Telephone number ______________________

Email address______________________ License ID # ______________________

Street address ______________________

City______________________ State________ Zip ______________________

6. 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. 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. 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.

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, having a normal work week of 25 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.
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.

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 sell 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.

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.

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.