FLORIDA HOSPITAL CARE ADVANTAGE
Underwritten by HealthFirst Commercial Plans

Large Group Application

6450 US Highway 1, Rockledge, Florida 32955
Toll-free 844.552.5279
myFHCA.org

For Florida Hospital Care Advantage 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.

Florida Hospital Care Advantage 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. Florida Hospital Care Advantage agrees never to sell your information. By submitting your email address, you expressly agree to receive promotional information from Florida Hospital Care Advantage, 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.

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Nondiscrimination Notice

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

Florida Hospital Care Advantage:

- 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 Florida Hospital Care Advantage 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@health-first.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.*

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English:
If you, or someone you're helping, has questions about Florida Hospital Care Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 844-522-5279.

Spanish:
En caso que usted, o alguien a quien usted ayude, tenga cualquier duda o pregunta acerca de Florida Hospital Care Advantage, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 844-522-5279.

Haitian Creole:
Si oumenm oswa yon moun w ap ede gen kesyon konsènan Florida Hospital Care Advantage, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 844-522-5279.

Vietnamese:
Nếu Quý vị, hay người mà Quý vị đang giúp đỡ, có câu hỏi về Florida Hospital Care Advantage thì Quý vị có quyền được trợ giúp và được biết thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, xin gọi số 844-522-5279.

Portuguese:
Você ou alguém que você estiver ajudando tem o direito de tirar dúvidas e obter informações sobre os Florida Hospital Care Advantage no seu idioma e sem custos. Para falar com um tradutor, ligue para 844-522-5279.

Chinese:
如果您，或是您正在協助的對象，有與 Florida Hospital Care Advantage
相關的問題，您有權以您的母語免費取得幫助和資訊。請致電 844-522-5279 與翻譯員洽談。

French:
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Florida Hospital Care Advantage, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 844-522-5279.

Tagalog:
Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Florida Hospital Care Advantage, may karapatan ka na humingi ng tulong at impormasyon sa iyong wika nang libre. Upang makausap ang isang tagasalin, tumawag sa 844-522-5279.

Russian:
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Florida Hospital Care Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 844-522-5279.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Florida Hospital Care Advantage، فلديك الحق في الحصول على المساعدةوالمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بالرقم 844-522-5279

Italian:
Se lei o qualcuno che sta aiutando avete domande su Florida Hospital Care Advantage, ha il diritto di ottenere aiuto e informazioni nella sua lingua gratuitamente. Per parlare con un interprete, può chiamare il numero 844-522-5279.

German:
Falls Sie oder jemand, dem Sie helfen, Fragen zum Florida Hospital Care Advantage haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 844-522-5279 an.

Korean:
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Florida Hospital Care Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 844-522-5279로 전화하십시오.

Polish:
Jeśli Ty lub osoba, której pomagasz, macie pytania na temat Florida Hospital Care Advantage, macie Państwo prawo do bezpłatnego uzyskania informacji i pomocy w języku ojczystym. Aby porozmawiać z tłumaczem, prosimy zadzwonić pod numer 844-522-5279.

Gujarati:
જો તમે અથવા તમે કોઇને મદદ કરી રહ્યા હો તેમાંથી કોઇને ફ્લોરિડા હોસ્પિટલ કેર એડવાંટેજ વિશે પ્રશ્નો હોય તો તમને તમારી ભાષામાં વિના મૂલ્યે મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 844-522-5279 પર કોલ કરો.

Thai:
หากคุณหรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Florida Hospital Care Advantage
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการพูดคุยกับล่าม โปรดโทร 844-522-5279.