FLORIDA HOSPITAL CARE ADVANTAGE

Continuation of Coverage Form

6450 US Highway 1, Rockledge, Florida 32955
Toll-free 844.522.5279
myFHCA.org

Employer name	Group #	Policy	Employer authorization

Section 1

Select type of continuation: ___COBRA (Federal continuation of coverage for employers with 20 or more employees

Qualifying event	Date event occurred	Qualifying event	Date event occurred
___Termination of employment		___Legal separation	
___Death of employee		___Ineligibility of dependent child	
___Reduction of work hours		___Divorce	
___Medicare entitlement		___Other (explain)	

Section 2 Employee information

Applicant SSN	Plan name _____ Plan type __HMO __POS	E-mail	
Applicant last name	First name	MI	Phone

Home street address	City	State	Zip

Section 3 List those electing to continue coverage

Name	Relationship	SS#	Sex	Date of Birth	PCP	New patient? (Y/N)	Employed full time? (Y/N)
Applicant							
Dependent							
Dependent							
Dependent							
Dependent							
Dependent							

I hereby elect the above enrollment or change to my enrollment with Florida Hospital Care Advantage. I authorize those providing services to me to release relevant information or medical records (may contain HIV/AIDS, psychiatric and/or chemical dependency treatment information) to Florida Hospital Care Advantage. FHCA agrees to comply with all HIPAA privacy regulations. **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 Spouse Signature Date

Health First Commercial Plans, Inc. is doing business under the name of Florida Hospital Care Advantage. Florida Hospital Care Advantage 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.