FLORIDA HOSPITAL CARE ADVANTAGE

Underwritten by Health First Commercial Plans

Large Group Quote Questionnaire

6450 US Highway 1, Rockledge, Florida 32955
myFHCA.org

1. Group Information

Legal name of company____ Date business established______________________

Street address____

City____ State________ County_________________ Zip ________________

Telephone____________________ Fax________________________ E-mail _____________________________________

Contact person ______________________________________ Title ____

Does your company have additional locations? ___No ___Yes (If yes, please explain below:)

____

Current carrier? ____________________________ Anniversary date _________________ How long with carrier? _________

Current rates: Employee______ Employee + Spouse________ Employee + Child(ren)________ Employee + Family _________

Renewal rates: Employee______ Employee + Spouse________ Employee + Child(ren)________ Employee + Family ________

Current plan design(s): ___HMO ___POS +++*Attach current plan designs*+++

2. Eligibility/Participation

Classes of eligible employee (check all that apply):
___Active Full Time (How many hours worked per week _____)
___Part-Time (How many hours worked per week _____)
___Leave of Absence (Provide LOA Policy)
___Retiree (Provide Retirement Policy)
___Other, please describe ____

Do all eligible employees live in Flagler or Volusia County? __Yes __No
If no, list the zip codes ____

Employer contribution: _________________________ Does the employer offer an incentive to waive coverage? __Yes __No

Waiting period: ____

Are any present or former employees or dependents currently on or eligible to elect continuation of coverage (COBRA)? __No __Yes
If yes, please list their names, dates they started continuation and the qualifying event:

____

____

Are any employees currently not actively at work, or on Leave of Absence? __No __Yes (If yes, please explain below:)

____

Do any eligible employees or dependents spend more than 30 consecutive days outside of the Florida Hospital Care Advantage service area (Flagler and Volusia Counties)? __No __ Yes (If yes, please provide details below:)

____

Provide census listing gender, date of birth and dependent status.

3. Other Required Information

Has anyone had a claim over $10,000 in the past two years? __No __Yes (If yes, provide information below)

Gender	*Date of Birth*	*Diagnosis*	*Occurrence Date*	*Claims Paid*	*Prognosis*

Has anyone been treated for a serious illness, been hospitalized or had surgery in the past twelve months: __Yes __No

Does anyone have a continuing claim for an existing mental or physical disorder? __Yes __No

Has anyone been advised to have surgery in the last six months or anticipate hospitalization for any reason? __Yes __No

Is there any employee or dependent currently pregnant in the third trimester? __Yes __No

Are there any handicapped dependents over the limiting age to be covered in the group? __Yes __No

If yes, are the handicapped dependents insured by the current group plan? __Yes __No

If you answered yes to any of the above questions, please provide additional details:

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____

____

4. Broker Information

Agent/Broker Name ______________ Tax ID/SS# ______________

Agency Name ______________ Telephone Number ______________ Fax ______________

Special considerations, if any: ____

____

V. Applicant Certification

Applicant's Signature ______________ Applicant's Title ______________ Date ______________

Soliciting Agent's Signature ______________ Requested Effective Date ______________

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