Other Coverage Form

for employer group eligible employees
Please print using black ink. Initial all corrections.

6450 US Highway 1, Rockledge, Florida 32955
Toll-free 844-522-5279
www.myFHCA.org

This form must be completed and signed by the subscriber (employee) attesting to prior creditable coverage or current coverage for all family members applying for coverage with Florida Hospital Care Advantage.

Please provide names and information for all family members, who are electing coverage with Florida Hospital Care Advantage that had coverage under a prior insurer's health plan during the previous 12 months (24 months for one-life groups / sole proprietor), or currently covered by another health insurer.

Name of Employee and Dependents	Social Security Number	Name of Insurance Company	Group / Policy Number	Effective Date	Termination

____Please check if no prior coverage applies.

Attach Certificate(s) of Creditable Coverage, if available, for each covered person listed above from prior insurer(s) in order to verify prior carrier coverage.

I agree that if my dependents or I have not been continuously covered by creditable coverage within the last 12 months, my dependents and I, as applicable may be subject to pre-existing condition exclusions. Pre-existing conditions do not apply to dependents under the age of 19 regardless of prior coverage as a result of the Patient Protection and Affordable Care Act. I hereby affirm that any applicable dependents and I have maintained creditable coverage under the plan(s) indicated above. I authorize Florida Hospital Care Advantage to obtain information from any of the above insurers, which includes but is not limited to medical records, coverage dates and reason for termination in order to verify coverage. I understand and agree that Florida Hospital Care Advantage reserves the right to adjust the pre-existing condition exclusion determination of any member accordingly and to financially recover any claims paid in error.

I certify that all information provided is accurate and complete. I further understand any person who knowingly and with the intent to injure, defraud or deceive any insurer, or files a statement of claim or application containing false, incomplete or misleading information may be subject to contract rescission and is guilty of a felony of the third degree.

EMPLOYEE SIGNATURE DATE

 Florida Hospital Care Advantage is administered by Health First Health Plans, Inc. Health First Health 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.