



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

Small Group Renewal Checklist

Group name: _____

Group number: _____

To renew your coverage with Florida Hospital Care Advantage, please complete these four items and return to us by the deadline shown on your Small Group Renewal Notice:

1. Participation Verification Form —*or*— UCT-6 form listing employees' hours (if no UCT-6, send Participation Verification form *and* Schedule C, F, or 1120S with K-1 schedules).
2. Copies of insurance ID cards for any employees with other group coverage and waiving FHCA coverage.
3. Small Group Renewal Checklist.
4. Small Group Renewal Notice.

Company information

Group legal name: _____

Authorized group contact(s): _____

Mailing/billing address: _____

Physical address: _____

Phone: _____ Fax: _____

Contact e-mail address: _____ Tax ID number: _____

Continuation of coverage

Under federal law, if your group had 20 or more employees on your payroll on at least 50% of your working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had fewer than 20 employees, you must provide state continuation (FHICCA).
 Select one:
 COBRA
 FHICCA

Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, coverage with HF is primary and Medicare is secondary. Otherwise, Medicare is primary and HF is secondary.
 Select one:
 HF primary/Medicare secondary
 Medicare primary/HF secondary

HR policies

Leave of absence policy(s) (if applicable) Yes, attached. No leave policy.

Waiting period for coverage to become effective for new employees

- | | |
|--|---|
| <input type="checkbox"/> Date of hire | <input type="checkbox"/> First day of the month 90 days after date of hire |
| <input type="checkbox"/> First day of the month after date of hire | <input type="checkbox"/> 120 days after date of hire |
| <input type="checkbox"/> 30 days after date of hire | <input type="checkbox"/> First day of the month 120 days after date of hire |
| <input type="checkbox"/> First day of the month 30 days after date of hire | <input type="checkbox"/> 150 days after date of hire |
| <input type="checkbox"/> 60 days after date of hire | <input type="checkbox"/> First day of the month 150 days after date of hire |
| <input type="checkbox"/> First day of the month 60 days after date of hire | <input type="checkbox"/> 180 days after date of hire |
| <input type="checkbox"/> 90 days after date of hire | <input type="checkbox"/> First day of the month 180 days after date of hire |

Employer contribution _____ % per employee and _____ % for dependents

—*or*— \$_____ per month

Plan selection

+++ Please remember to indicate your plan selection on the second page of the Renewal Notice. +++

Signature

 Officer of Company Title Date