Health First Health Plans

Underwritten by Health First Commercial Plans

6450 US Highway 1, Rockledge, Florida 32955
Toll-free 855.443.4735
myHFHP.org

Small Group Application

For Health First use only:

Group number	Division number

1. Group Information

Legal name of applicant _____

Doing Business As (DBA) _____ Date established _____

Street address _____

City_____ State_____ County_____ Zip _____

Telephone_____Fax _____

Federal identification number_____ Nature of business _____

Legal status: ☐ Corporation ☐ Partnership ☐ Other _____

Contact person_____ Title _____

Email address _____

Billing address (if different) _____

City_____ State_____ Zip _____

Are there any affiliates or subsidiaries to be covered? ☐ No ☐ Yes (list) _____

_____

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 number of days, 90-day maximum waiting period):
   ☐ First of the month following _____ days, or
   ☐ Day following _____ days, or
   ☐ Date of hire
3. Waive waiting period with initial group application? ☐ Yes ☐ No
4. Do eligible employees include (check all that apply): ☐ Full time employees ☐ Leased ☐ Part time
   ☐ 1099s (requires 1096) ☐ Other (explain) _____
5. Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the current or preceding calendar year, Health First is primary and Medicare is secondary. If your group does not meet this requirement, Medicare is primary and Health First is secondary. For your group:
   ☐ Medicare is primary (less than 20 employees) ☐ Health First is primary (20 or more employees)

6. Under federal law, if your group had 20 or more employees on your payroll for at least 50% of the employer's working days of the preceding calendar year, you must provide employees with Consolidated Omnibus Benefits Reconciliation Act (COBRA) continuation. If your group had fewer than 20 employees, you must provide state continuation. You offer:

   ☐ COBRA (20 or more employees) Administered by: _____

   ☐ State Continuation, Florida Health Insurance Coverage Continuation Act (FHICCA)

7. Are any present or former employees or dependents currently on or eligible to elect continuation of coverage (COBRA or FHICCA) under your group plan? ☐ No ☐ Yes

   If yes please list their names, dates they started continuation and qualifying event:

   Name *Date* *Qualifying Event*

   _____

   _____

   _____

8. Please fill in the number of employees in each category:

On the payroll	Employees working 25+ hours/week	Part-time employees	In waiting period	Total number electing HF coverage (including Continuation beneficiaries)	Declining with no other group coverage	Declining with other group coverage

3. Medical and Billing Plan Selection

Medical Plans:

☐ HMO ☐ POS Plan option: _____

☐ HMO ☐ POS Plan option: _____

☐ HMO ☐ POS Plan option: _____

Plan Billing:

Final rates are based on enrollment as of the effective date of coverage and may vary from illustrative quote.

Please select your billing option: ☐ Age Table Rates ☐ Composite Rates

4. 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_____

5. 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. 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

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.

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 (25 hours per week) 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 on the plan or have proof of creditable coverage. If the applicant pays less than 100% of the premium, 70% of the eligible employees must be insured (or 50% if enrolled in Affordable Choice Program).*
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.*

Health First Health Plans 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. Health First agrees never to sell your information. By submitting your email address, you expressly agree to receive promotional information from Health First facilities, 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

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

Health First Health Plans:

- 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 Health First Health Plans 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 Health First Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-443-4735.

Spanish:
En caso que usted, o alguien a quien usted ayude, tenga cualquier duda o pregunta acerca de Health First Health Plans, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-443-4735.

Haitian Creole:
Si oumenm oswa yon moun w ap ede gen kesyon konsènan Health First Health Plans, 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 855-443-4735.

Vietnamese:
Nếu Quý vị, hay người mà Quý vị đang giúp đỡ, có câu hỏi về Health First Health Plans 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 855-443-4735.

Portuguese:
Você ou alguém que você estiver ajudando tem o direito de tirar dúvidas e obter informações sobre os Health First Health Plans no seu idioma e sem custos. Para falar com um tradutor, ligue para 855-443-4735.

Chinese:
如果您，或是您正在協助的對象，有與 Health First Health Plans
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 855-443-4735 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 Health First Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-443-4735.

Tagalog:
Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Health First Health Plans, may karapatan ka na humingi ng tulong at impormasyon sa iyong wika nang libre. Upang makausap ang isang tagasalin, tumawag sa 855-443-4735.

Russian:
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Health First Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 855-443-4735.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Health First Health Plans، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بالرقم 855-443-4735.

Italian:
Se lei o qualcuno che sta aiutando avete domande su Health First Health Plans, ha il diritto di ottenere aiuto e informazioni nella sua lingua gratuitamente. Per parlare con un interprete, può chiamare il numero 855-443-4735.

German:
Falls Sie oder jemand, dem Sie helfen, Fragen zum Health First Health Plans 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 855-443-4735 an.

Korean:
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Health First Health Plans에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 855-443-4735로 전화하십시오.

Polish:
Jeśli Ty lub osoba, której pomagasz, macie pytania na temat Health First Health Plans, macie Państwo prawo do bezpłatnego uzyskania informacji i pomocy w języku ojczystym. Aby porozmawiać z tłumaczem, prosimy zadzwonić pod numer 855-443-4735.

Gujarati:
જો તમે અથવા તમે કોઇને મદદ કરી રહ્યા હો તેમાંથી કોઇને હૅલ્થ ફર્સ્ટ હૅલ્થ પ્લાન્સ વિશે પ્રશ્નો હોય તો તમને તમારી ભાષામાં વિના મૂલ્યે મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 855-443-4735 પર કૉલ કરો.

Thai:
หากคุณหรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Health First Health Plans
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการพูดคุยกับล่าม โปรดโทร 855-443-4735.