Health First
Health Plans

Continuation of Coverage Form

6450 US Highway 1, Rockledge, Florida 32955
Toll-free 855.443.4735
myHFHP.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 __PPO	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 Health First. 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 Health First. Health First 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