



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
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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
<input type="checkbox"/> Termination of employment		<input type="checkbox"/> Legal separation	
<input type="checkbox"/> Death of employee		<input type="checkbox"/> Ineligibility of dependent child	
<input type="checkbox"/> Reduction of work hours		<input type="checkbox"/> Divorce	
<input type="checkbox"/> Medicare entitlement		<input type="checkbox"/> Other (explain)	

Section 2 Employee information

Applicant SSN	Plan name _____ Plan type <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> 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

Health First Commercial Plans, Inc. and Health First Insurance, Inc., are both doing business under the name of Health First Health Plans. 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.