Health Plans

Underwritten by Health First Commercial Plans

Enrollment/Change Form

for large employer groups

Please print using black ink. Initial all corrections.
All questions must be answered.

This section to be completed by Benefit Administrator:

Company Name: ______________________ Initial Enrollment ________ Waiving Coverage _____
Complete Section 5

Group #: ______________________ Open Enrollment ________

Division #: ______________________ COBRA ________ Qualifying Event _____
Complete Section 6

Date of Hire/Termination: ______________________ Effective Date: ________

Section 1. Type of Transaction *(Check all that apply)*

__Enrollment: __Employee __Retiree __Spouse __Child(ren)

__Change: __Name __Address __Plan __Division __Coverage __Termination __Dependent Termination

Section 2. Employee Information

*(Must attach copy of supporting documentation if dependent has a different last name than the employee. See **Supporting Documentation**, section 6)*

Applicant SSN / Member ID:	First Name:	M.I.	Last Name:

Home Address:	Apt. #:	City:	State:	Zip:
Mailing Address (if different than above):	Apt. #:	City:	State:	Zip:

Phone #:	Cell Phone #:	Email Address:

Date of Birth (mm/dd/yyyy):	Sex:	Plan Name:	Occupation:
____ ____ / ____ ____ / ____ ____ ____ ____	Male Female		

Subscriber's PCP (first, last name):

Section 3. Enrollment / Change Information

*(Must attach copy of supporting documentation for qualifying event. See **Supporting Documentation**, section 6):*

Change Type: (A=Add, C=Change, T=Termination)	***First Name***	***M.I.***	***Last Name***	***Relationship to Applicant***	***Social Security #***	***Sex M/F***	***Date of Birth***	***Dependent's PCP (first, last name)***

1) Does any dependent listed above have a permanent residence different than the applicant? ___Yes ___No
If yes, provide name of dependent and address: ____
2) Does any dependent child listed above have a permanent physical or mental handicap? ___Yes ___No
If yes, provide name of dependent and age when the handicap was diagnosed: ______________________________

Section 4. Other Coverage Information

Complete this section only if you or any of your dependents have other health coverage that will not be cancelled when the coverage under this application becomes effective. List names of each individual covered. If you and/or your dependents will not have other coverage, please initial _______.

Group Coverage __Yes __No	Name and Address of Other Insurance Carrier

Effective Date (MM/DD/YYYY)	Type of Policy __Employee Only __Employee/Spouse __Employee/Child(ren) __Family

Name of Policyholder (First, Last)	Birth Date (MM/DD/YYYY)	__Male __Female

Relationship to Applicant __Self __Spouse __Dependent	Employer's Name	Employment Start Date (MM/DD/YYYY)

Group Number	Policy Number

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name & Date of Birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B" when this dependent is covered under both you and your spouse's insurance plan (married).
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

I understand that any person who knowingly and with intent to injure, defraud, or deceive and insurer files a statement of claim or an application containing and false, incomplete or misleading information is guilty of a felony of the third degree. **Initial**_____________

Section 5. Waive Coverage (if applicable)

Medical coverage

___I am declining coverage for: __Myself ___Spouse ___Child(ren) *(check all that apply)*
Reason for declining coverage: ___Other coverage ___Medicare ___TriCare ___No coverage
(check all that apply and provide copy of ID card)

Section 6. Qualifying Event (if applicable)

Event date: _____________ Qualifying event: _____________________ Documentation attached? ___Yes ___No

***Supporting documentation** is showing evidence of his/her dependent status (birth certificate, court order for guardianship, marriage certificate, adoption papers, etc.) for either qualifying event or if adding a dependent with a different last name than that of the employee. Must attach copy for coverage.*

Section 7. Attestation

Coverage Terms:

I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer applications have been accepted and approved by Health First. I hereby elect the above enrollment or change to my enrollment with Health First. I authorize my employer to deduct from my earnings my share of the payment for coverage and to make any necessary payments to the plan. I understand that my coverage/membership is to be issued and continued on the basis that I and any dependents covered under this coverage/membership, must meet all of the requirements of my plan.

I am aware and understand that membership granted to persons herein shall be subject to all provisions and limitations of the group contract. I am aware that a change in coverage of dependents may affect the amount deducted from my paycheck for these benefits, and I hereby authorize any such change.

If I am in a high-deductible health plan designated for use with a Health Savings Account (HSA) under Internal Revenue Service Code section 223, I recognize and authorize Health First to exchange certain limited information obtained from this application with its preferred financial partner(s) for the purposes of initial enrollment in, and administration of, HSAs.

I understand that if I am in a HSA qualified High Deductible Health Plan and I elect to receive Prior Carrier Credit under Florida law, my plan may no longer qualify as an HSA compatible plan.

General Terms:

1. *I agree that in the event of any controversy or dispute between Health First, I and my dependents must exhaust the appeal and/or grievance processes in the benefit/member handbook issued to me.*
2. *When an overpayment is made, I authorize Health First to recover the excess from any person or entity that received it.*
3. *I acknowledge that, if I apply for Health First coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period.*
4. *I understand and agree that this Enrollment/Change Request form may be transmitted to Health First or its agent by my employer. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers"), including pharmacies or pharmacy database benefit managers to give to Health First or its agent information concerning the medical history, medical records (may contain HIV/AIDS, psychiatric and/or chemical dependency treatment information), prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health and substance abuse. I further authorize Health First to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. The plan agrees to comply with all HIPAA privacy regulations. I have discussed the terms of this authorization with those affected by this Enrollment/Change Request form, and I have obtained their consent to those terms. I understand I may cancel this authorization in writing to the plan and unless revoked this authorization will remain valid for the terms of the coverage and for so long as thereafter allowed by law.*

To the best of my knowledge and belief, I represent that all information supplied in this form is true and complete. On behalf of myself and the eligible persons listed herein, I acknowledge that I have read and understand this form in its entirety. I understand that in the event that I fail to sign this form after the above transaction request or for any reason Health First does not receive notice of the above transaction request within a reasonable time following the event, mine and my dependents' eligibility may be affected.

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 *DATE*

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.