Health First Health Plans

Underwritten by Health First Commercial Plans

Enrollment/Change Form

for small 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 _____

Group #: _____ Open Enrollment _____ *Complete Section 5*

Division #:_____ COBRA / FHICCA _____ Qualifying Event _____

Date of Hire/Termination: _____ Effective Date: _____ *Complete Section 6*

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** below.):*

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** below.):*

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 (if applicable)

I understand that 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. 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.

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.*
5. *I understand that my employer is not an agent of Health First Commercial Plans, Inc. I also understand that my employer is responsible for notifying all employees of: 1. Effective dates; 2. All termination dates; 3. Any conversion, COBRA or ERISA rights or responsibilities; and 4. All other matters pertaining to coverage/membership under the group contract.*

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.

Health First

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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*.

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.

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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.