Health First Health Plans
Underwritten by Health First Commercial Plans

Contract ID Number:_____

Individual Coverage Application (2019)

For Off-Marketplace Plans—For New and Renewing Coverage

This application must be completed in its entirety or processing time may be delayed. Applicants must reside within the Health First Health Plans service area to be eligible for coverage.

Send original completed application to:
Health First Health Plans
Attention: Sales
6450 US Highway 1
Rockledge, Florida 32955

myHFHP.org
Sales Department: Toll-free **1.877.904.4914**
Fax: 321.434.4270 ■ TDD/TTY: 1.800.955.8771
November 1–December 15: Call weekdays 9 am to 6 pm
December 16–October 31: Call weekdays 9 am to 5 pm

Application requirements and instructions

- This Application must be filled out by the Applicant. You (the Applicant) are responsible to guarantee the information provided is accurate, complete, and truthful. Failure to complete any section will result in a delay in processing your application.
- **Do not cancel any health insurance coverage you currently have or decline COBRA benefits until you receive notice of acceptance from Health First Health Plans**. Please retain a copy of this application for your records.
- Any misrepresentation of information on the Application may result in cancellation of coverage.
- Any family member of an Applicant who is age 18 or older must also sign and date the Application.
- All eligible family members must apply on one application.
- A dependent from age 26 to age 30 must meet the eligibility requirements in accordance with Florida law.
- To obtain coverage for a member's newborn or adopted child outside of the annual open enrollment period, a policyholder must complete and submit an Individual Coverage Application or Change Form within sixty (60) days of the child's birth or placement in the home. Send the completed Application, with first month's premium payment, if applicable, to Health First Health Plans at the address above.
- . Please be advised that your quoted premium may be adjusted by Health First Health Plans as a result of enrollment fees, billing options, benefit/plan changes, available effective dates, age/birth date, or any other relevant factors.
- Health First Health Plans complies with all federal regulations including guarantee issue provisions as outlined in the Health Insurance Portability and Accountability Act (HIPAA), and in the Affordable Care Act (ACA).
- Please enter your benefit plan selection in Section 3 of the Application.
- All information is confidential.

Must be completed in blue or black ink.

Section 1: PRIMARY APPLICANT INFORMATION

Primary Applicant's Name/Last			First		M.I.
Marital Status ☐ Single ☐ Married			Occupation		
Home Address *(No P.O. Box):* Street		Apt.	City	State	Zip
Home phone ( )	Work phone ( )	Cell phone ( )	Other ( )	Best time to call ☐ AM ☐ PM ☐ Any	
E-mail address _____			*By providing my email address, I am authorizing Health First Health Plans to send any and all communications regarding this Application via secure email.*		

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Section 2: ADDITIONAL APPLICANT INFORMATION

	Sex	Name (Last, First, MI)	US citizen?	Social Security Number	Date of Birth (MM/DD/YYYY)	Tobacco use in the past 6 months?
1	M / F	Primary Applicant	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __/__ __ __ __	Yes / No
2	M / F	Spouse	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __/__ __ __ __	Yes / No
3	M / F	Dependent Child	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __/__ __ __ __	Yes / No
4	M / F	Dependent Child	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __/__ __ __ __	Yes / No
5	M / F	Dependent Child	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __/__ __ __ __	Yes / No
6	M / F	Dependent Child	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __/__ __ __ __	Yes / No
7	M / F	Child of Dependent Child	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __/__ __ __ __	Yes / No
8	M / F	Child of Dependent Child	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __/__ __ __ __	Yes / No

I attest that the children listed on this application are my legal dependents. Initial _____

Section 3: PLAN SELECTION

Medical plan—All medical plans are compliant with the Affordable Care Act and cover all required Essential Health Benefits, including Pediatric Dental and Vision. Please mark your plan choice:

Plan name:_____ Plan number (4 digits): __ __ __ __
(For example "HF Silver HMO 80") *(For example "1354")*

Requested effective date
(Health First will attempt to provide you with the requested effective date however the requested effective date is not guaranteed.)

__Jan. __Feb. __Mar. __April __May __June __July __Aug. __Sept. __Oct. __Nov. __Dec.

Section 4: PRIOR/OTHER COVERAGE *Optional for renewing members*

A. Have you or any Applicant ever been a member of an individual or group plan with Health First? ☐ Yes ☐ No
If yes, please provide the member's name and Policy number:

_____

_____

B. Do you or any applicant have health insurance coverage which ended within the last 60 days? ☐ Yes ☐ No
If yes, please provide Applicant's name, insurance company's information, type of coverage, effective date, and termination date:

_____

_____

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C. Do you or any applicant currently have health insurance?

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	Coverage 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 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. **Initial**_____

Section 5: CONDITIONS of ENROLLMENT Please carefully read the information below.

GENERAL CONDITIONS: Coverage will only apply to services provided on or after the effective date of coverage.
PAYMENT OF PREMIUM: Please note that this coverage is not to be sold as a commercial group policy. Each Applicant is responsible for the initial premium as well as any future payments. If funds are drawn from a business account, I certify that I am the business owner and the payments are for myself and/or other Applicants as individuals and not as employees. I understand that payments from a business account are not for employees or others outside of my immediate family. Refund of premium is only payable to the primary Applicant. If your policy terminates due to non-payment of premium, Health First Health Plans has the right to apply to any past-due premium amounts owed, the initial premium payment made for new coverage within the 12-month period and past-due balances accumulated within the previous 12-month period prior to the coverage start date may be required before any new coverage commences.
BINDING AGREEMENT: The applicable Health First Health Plans Certificate of Coverage and this Application, (collectively the "Contract"), shall constitute the entire agreement between the Applicant(s) and Health First Health Plans. The Applicant(s) hereby agree to be bound by the terms and conditions as set forth in the Contract if accepted for coverage in accordance herewith. **PLEASE RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS.**

The Applicant's signature below shall constitute acceptance of the Contract on behalf of such Applicant and the primary Applicant's signature shall constitute acceptance of the Contract for any Dependent Applicant(s) who are under the age of 18, as listed in Section 2 above.

I hereby agree that the Contract shall automatically renew on January 1 of each year and any benefit changes required to comply with the Affordable Care Act or state statutes will be included as of that effective date subject to any and all amendments to the Contract, including rate or benefit changes, as determined by Health First Health Plans or elected by me on behalf of myself and all Applicants, without my express consent unless I, any Applicant, or Health First Health Plans determines to terminate the Contract in accordance with its terms.
OMISSION CLAUSE: I represent that all statements and answers made in this document, by whomsoever written including its reverse side and on any attached papers, are complete, true and correct to the best of my knowledge. I agree that this shall be the basis of my and all Applicants' acceptance of enrollment with Health First. I understand that Health First Health Plans will rescind coverage only due to an act or practice constituting fraud or an intentional misrepresentation of a material fact.
COUNTERPARTS: This Application may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall constitute a single agreement.

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USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please read the following carefully before completing your application. This notice describes how medical information about you may be used and disclosed.

Health First Health Plans is committed to protecting the privacy of your medical and member information also known as Protected Health Information (PHI). We collect and maintain this information to administer our business, to provide you with products, services, information of importance, and to comply with certain legal requirements. This notice tells you about the ways in which we may use and disclose your information. It also describes your rights and certain obligations we have regarding the use and disclosure of your information.

We are required by law to protect the privacy of your information, notify affected individuals following a compromise of unsecured PHI, provide this notice about our privacy practices, and follow the privacy practices that are described in this notice.

We may use and disclose PHI without your authorization for the following reasons. Not every use or disclosure will be listed below. However, all the ways we're permitted to use and disclose information will fall within one of the categories.

To provide treatment: We may disclose your PHI to your health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who may request it in connection with your treatment. We may also disclose your PHI to health care providers (including their employees and business associates) in connection with preventative health, early detection and disease and case management programs.

For payment purposes: We may use or disclose your PHI to administer your health care policy or contract which may involve: determining your eligibility for benefits, paying claims for services you receive, making medical necessity determinations, coordinating your care of other services and coordinating your coverage with other plans.

For healthcare operations: We may use and/or disclose your PHI to support daily business activities for healthcare operations, which may include activities like quality management, care management, care coordination, credentialing, medical review, auditing, legal services, business planning and development, public health activities, abuse or neglect, legal proceedings, law enforcement officials, worker's compensation and as required by law.

We may disclose your PHI to a representative acting on your behalf. You must appoint your representative in writing and provide the written appointment to Health First Health Plans at the address included below.

We may disclose your PHI to a friend or family member who is involved in, or helps pay for your care. In addition, we may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition, status and location. You have the right to object to disclosure of your PHI to a friend or family member in this case.

Other than the uses and disclosures described above, we will not disclose your PHI without your written authorization. Health Plan requires your written authorization for most uses and disclosures of psychotherapy notes (psychotherapy notes are notes made by a mental health professional during a private, group or family therapy session and kept separate from the medical record) for marketing (other than a face-to-face communication between you and a Health Plan workforce member or a promotional gift of nominal value) in which financial payment is received or before selling your protected health information resulting in financial or non-financial payment. Additionally, other uses and disclosures of medical information not covered by this notice or by the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

You have rights related to the use and disclosure of your PHI. To exercise these rights, you may contact the locations below:

Health First Health Plans
6450 US Highway 1
Rockledge, FL 32955
PH: 1.855.443.4735

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ACKNOWLEDGEMENT and AGREEMENT: I understand and agree to abide by all terms, conditions and provisions of the Contract. I have read and understand this Application including the conditions of enrollment. I understand if this Application is accepted it will become part of the Contract. My signature (either signed below or electronically submitted) indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct.

❑ By checking this box and entering my name and date below, I am indicating my intent to electronically sign this Application and warrant that all of the information I have provided is true, complete, and accurate. I acknowledge having been provided the required forms during the application process.

Print Name		**Date**		**X**	
	Primary Applicant				Signature of Primary Applicant
Print Name		**Date**		**X**	
	Spouse (if applying for coverage)				Signature of Spouse
Print Name		**Date**		**X**	
	Dependent (Required if age 18 or older)				Signature of Dependent
Print Name		**Date**		**X**	
	Dependent (Required if age 18 or older)				Signature of Dependent
Print Name		**Date**		**X**	
	Dependent (Required if age 18 or older)				Signature of Dependent
Print Name		**Date**		**X**	
	Dependent (Required if age 18 or older)				Signature of Dependent

Section 6: ACKNOWLEDGEMENT

IT IS IMPORTANT YOU REVIEW AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By submitting an application for benefits, I agree with all of the statements listed below:

- I attest the information submitted in this Application is true and accurate to the best of my knowledge. 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.
- Once benefits are effective, they are contingent on timely and accurate payment of premiums and any other cost sharing as outlined in the policy. If payment is not accurate and paid on time, my coverage will be terminated. If terminated for non-payment, I may no longer be eligible to enroll in Health First Health Plans.

Authorization for electronic signature

❑ By checking this box and entering my name below, I am indicating my intent to electronically sign this Application and warrant that all of the information I have provided is true, complete, and accurate. I acknowledge having been provided the required forms during the application process.

Print Name of Primary Applicant | Signature of Primary Applicant | Date

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Section 7: STATEMENT of ACCOUNTABILITY *Complete if the Applicant cannot or has not completed the application.*

I have personally read and completed the Individual Application for the applicant because:

- Applicant is a minor and I am the applicant's parent or legal guardian.
- Applicant does not have command of the English language in order to complete this application.
- The Applicant is legally incapacitated and unable to complete this application.

I have read and explained in detail the contents of this application. If translated, I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal information disclosed by _____.

Proxy/Translator's Name (please print) **Date:** **X** Proxy/Translator's Signature

Section 8: INSURANCE PRODUCER INFORMATION

I have read the Application and all questions have been answered in full. **Incomplete Applications will be returned.** I verify that the Applicant has either physically or electronically signed this Application. Initials: _____

Agency Name:

Agency Address:

Street/Suite No. City State Zip

Agent Name: Print Date **X** Signature

Phone Number: Fax: Email address:

NPN#: Agent License Number:

Section 9: HEALTH FIRST HEALTH PLANS REPRESENTATIVE INFORMATION (for Internal use only)

Print Name: Last First

Signature: **Date:**

NPN#: Agent License Number:

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, 1-800-868-1019, 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.

Health First

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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.