



Customer Service 8 am–8 pm, 7 days a week

6450 US Highway 1, Rockledge, FL 32955 • Phone 321-434-5665 • Toll-free 1-800-716-7737 • Fax 321-434-4226 • hfhpinfo@health-first.org • www.healthfirsthealthplans.org

— Please PRINT and use blue or black ink —

Employer name _____ Group # _____ Division # _____

Section 1: Type of transaction (check all that apply)

Enrollment: Employee Spouse Child(ren) **Waive enrollment:** (complete Section 4) Employee Spouse Child(ren)
 Change: (complete Section 3) Name Plan Coverage Address Division PCP Termination Dependent termination

Section 2: Employee/applicant information

New group enrollment New hire Open enrollment Qualifying event (include required documentation) Add dependent

Applicant SSN _____ Hire/retire/rehire date (mm-dd-yyyy) _____
 Employee Retiree

Member number (N/A if new enrollee) _____

Plan name _____ Coverage/change effective date (mm-dd-yyyy) _____
 HMO POS

Applicant first name _____ Last name _____ MI _____

Home address _____

City _____ State _____ Zip _____

Phone _____ Occupation _____

E-mail _____

Section 3: Enrollment/change information

↓ Indicate type of change (A=add, C=change, T=termination)

1 A/C/T First name _____ Last name _____ MI _____ Sex (M/F) _____
Relationship to applicant _____ Date of birth (mm-dd-yyyy) _____ SSN _____ Employed full time? (Y/N) _____
Primary Care Physician: First name _____ Last name _____ New patient? (Y/N) _____

2 A/C/T First name _____ Last name _____ MI _____ Sex (M/F) _____
Relationship to applicant _____ Date of birth (mm-dd-yyyy) _____ SSN _____ Employed full time? (Y/N) _____
Primary Care Physician: First name _____ Last name _____ New patient? (Y/N) _____

3 A/C/T First name _____ Last name _____ MI _____ Sex (M/F) _____
Relationship to applicant _____ Date of birth (mm-dd-yyyy) _____ SSN _____ Employed full time? (Y/N) _____
Primary Care Physician: First name _____ Last name _____ New patient? (Y/N) _____

4 A/C/T First name _____ Last name _____ MI _____ Sex (M/F) _____
Relationship to applicant _____ Date of birth (mm-dd-yyyy) _____ SSN _____ Employed full time? (Y/N) _____
Primary Care Physician: First name _____ Last name _____ New patient? (Y/N) _____

Health First Health Plans



Creditable Coverage

This form must be completed and signed by the Subscriber (employee) attesting to prior creditable coverage for all family members applying for coverage with Health First Health Plans.

Please provide names and information for all family members, who are selecting coverage with Health First Health Plans that had coverage under a prior insurer's health plan during the previous 12 months (24 months for groups with fewer than 2 employees):

Name of Employee and Dependents	Social Security Number	Previous Insurer	Group or Member Number	Effective Date	Termination Date

Please attach Certificate(s) of Creditable Coverage, if available, from prior insurer(s) in order verify prior carrier coverage.

I hereby affirm that any applicable dependents and I have maintained creditable coverage under the plan(s) indicated above. I authorize Health First Health Plans to obtain information from any of the above insurers, which includes but not limited to medical records, coverage dates and reason for termination in order to verify coverage. I understand and agree that Health First Health Plans may audit such information and may request additional evidence of creditable coverage. I understand that if the information provided herein varies from information subsequently submitted, Health First Health Plans reserves the right to adjust the pre-existing condition exclusion determination of any member accordingly and to recoup dollars paid out in error.

I certify that all information provided is accurate and complete. I further understand any person who knowingly and with the intent to injure, defraud or deceive any insurer files a statement of claim or application containing false, incomplete or misleading information may be subject to contract rescission and is guilty of a felony of the third degree.

Employee Signature

Date