



Enrollment/Change Form

for employer group eligible employees

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 IV.
 Division #: _____ COBRA / FHICCA _____ Qualifying Event _____
 Date of Hire/Termination: _____ Effective Date: _____ Complete Section V.

Section I. Type of Transaction (Check all that apply)

Enrollment: Employee Retiree Spouse Child(ren)
 Change: Name Address Plan Division Coverage Termination

Section II. Employee Information

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 #:		E-mail Address:			Occupation:	
Date of Birth (mm/dd/yyyy): ____/____/____		Gender: Male / Female	Plan Type: HMO / POS	Plan Name:	Race / Ethnicity:	Language:

Section III. Enrollment / Change Information

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

Change Type: (A=Add, C=Change, T=Termination)	First Name	M.I.	Last Name	Relationship to Applicant	Social Security #	Gender M/F	Date of Birth

- 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 IV. Waive Coverage (if applicable)

(Must attach copy of supporting documentation for qualifying event. See Supporting Documentation below.)

I am declining coverage for: Myself Spouse Child(ren) (check all that apply)
 Reason for declining coverage: Other group coverage Medicare TriCare No coverage
 (check all that apply and provide copy of ID card)

Section V. 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.

I hereby elect the above enrollment or change to my enrollment with Health First Health Plans, Inc. 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 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 the plan. The plan 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

DATE



Other Coverage Form

for employer group eligible employees

6450 US Highway 1, Rockledge, FL 32955 • 321.434.5665 • 1.800.716.7737
www.HealthFirstHealthPlans.org

Please print using black ink. Initial all corrections.

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

Section VI. Prior / Other Coverage

Please provide names and information for all family members, who are electing coverage with Health First Health Plans that had coverage under a prior insurer's health plan during the previous 12 months (24 months for one-life groups / sole proprietor), or currently covered by another health insurer.

Name of Employee and Dependents	Social Security Number	Name of Insurance Company	Group / Policy Number	Effective Date	Termination Date

Please check if no prior coverage applies.

Attach Certificate(s) of Creditable Coverage, if available, for each covered person listed above from prior insurer(s) in order to verify prior carrier coverage.

I agree that if my dependents or I have not been continuously covered by creditable coverage within the last 12 months, my dependents and I, as applicable may be subject to pre-existing condition exclusions. Pre-existing conditions do not apply to dependents under the age of 19 regardless of prior coverage as a result of the Patient Protection and Affordable Care Act. 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 is 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 reserves the right to adjust the pre-existing condition exclusion determination of any member accordingly and to financially recover any claims paid 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, or 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 _____