

Health First Health Plans



Continuation of Coverage Form

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 hfhpinfo@health-first.org www.healthfirsthealthplans.org

EMPLOYER NAME	GROUP #	POLICY	EMPLOYER AUTHORIZATION
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Section I

Select type of continuation **COBRA** (Federal continuation of coverage for employers with 20 or more employees)
 FHICCA (State of Florida continuation of coverage for employers with fewer than 20 employees)

Qualifying event	Date event occurred	Qualifying event	Date event occurred
<input type="checkbox"/> Termination of employment		<input type="checkbox"/> Legal separation	
<input type="checkbox"/> Death of employee		<input type="checkbox"/> Ineligibility of dependent child	
<input type="checkbox"/> Reduction of work hours		<input type="checkbox"/> Divorce	
<input type="checkbox"/> Medicare entitlement		<input type="checkbox"/> Other (explain)	

Section II Employee information

Applicant SSN	Plan name and type	<input type="checkbox"/> HMO <input type="checkbox"/> POS	E-mail		
Applicant last name	First name	MI	Phone		
Home street address	City	State	Zip		

Section III List those electing to continue coverage

Name	Relationship to applicant	Social Security #	SEX	Date of birth	Primary Care Physician	New patient? (Y/N)	Employed full time? (Y/N)
Applicant	N/A						N/A
Dependent							
Dependent							
Dependent							
Dependent							
Dependent							

I hereby elect the above enrollment or change to my enrollment with Health First Health Plans, Inc. 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. 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 _____ SPOUSE SIGNATURE _____ DATE _____