INDIVIDUAL APPLICATION FOR INSURANCE

Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

DO NOT WRITE IN SHADED AREA - FOR FHCP USE ONLY

SMOKER ◯ YES ◯ NO

APPLICATION # _____

Relationship _____

SOURCE ◯ Conversion ◯ Group ◯ COBRA ◯ NEW

PART 1: APPLICANT PERSONAL INFORMATION

SOCIAL SECURITY NO.	LAST NAME	FIRST NAME	M.I.	SUFFIX (i.e., Jr.)

DATE OF BIRTH Mo. Day Yr.

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

GENDER: ☐ Male ☐ Female

HOME ADDRESS (Include Apt. #, Lot#, Route#) PO Box should NOT be indicated):

COUNTY

CITY

STATE

ZIP

MAILING ADDRESS (if different from above):

Street City State Zip

Home Telephone ( )

Cell ( )

Work ( )

Email:

HAVE YOU USED TOBACCO IN ANY FORM (e.g., cigarettes, cigars, pipes, snuff or chewing) IN THE PAST SIX MONTHS?
☐ **YES** ☐ **NO**

ARE YOU A U.S. CITIZEN OR U.S. NATIONAL?
☐ YES ☐ NO

WHAT IS YOUR PREFERRED LANGUAGE?

IF YOU ARE NOT A U.S. CITIZEN/NATIONAL, PLEASE COMPLETE YOUR IMMIGRATION STATUS BELOW:

Immigration Document Type: _____

Document I.D. Number: _____

Have you lived in the U.S. since 1966? ☐ YES ☐ NO

Are you a Veteran or on Active Duty? ☐ YES ☐ NO

If you need help in a language other than English, call 1-866-874-3972 for assistance at NO COST to you.

RACE (Optional):

☐ Hispanic/Latino
☐ Black or African American
☐ Caucasian or White
☐ American Indian/Alaskan Native
☐ Chinese
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Somoan
☐ Other: _____

PART 2: APPLICANT EMPLOYMENT & CURRENT HEALTH INSURANCE INFORMATION

EMPLOYMENT STATUS:

☐ Employed FT
☐ Employed PT
_____ average hrs./week
☐ Full-Time Student
☐ Self-Employed
☐ Retired
☐ Unemployed

Name of Employer/School: _____

☐ Located in Volusia, Flagler, Seminole or Brevard County?

Current Occupation/Title:

CURRENT DENTAL COVERAGE: ☐ YES ☐ NO

If yes, enrollment can continue. If no, pediatric dental must be purchased (Florida Combined Life or via Marketplace)

CURRENT HEALTH COVERAGE: ☐ YES ☐ NO

If the answer is YES, please indicate the type of health coverage from any of the following: (check all that apply)

☐ MEDICAID
☐ MEDICARE
☐ TRICARE
☐ OTHER GOVERNMENT/PUBLIC ASSISTED:
Name of Other Government/ Public Insurance _____

☐ Employer Sponsored (through your job)
☐ Student Health Insurance (through school)
Name of Insurance Company: _____

Policy No.: _____

PART 3: COVERAGE PURCHASED INFORMATION

PLAN NAME:

MONTHLY PREMIUM: $ _____
Tobacco Rated? ☐ Yes ☐ No
Initial Premium Paid? ☐ Yes ☐ No
BILLING METHOD: Monthly

COVERAGE EFFECTIVE DATE: _____
POLICY TERM: _____ MONTHS
RENEWAL DATE: JANUARY 1,

PAYMENT METHOD: ☐ Check/Money Order ☐ Cash ☐ Credit/Debit ☐ ACH ☐ Other

PART 4: ACKNOWLEDGMENT & SIGNATURE OF APPLICANT

- I acknowledge I am signing this application under penalty of perjury, which means I have provided true answers to the best of my knowledge. I understand that I may be subject to penalties under Federal Law if I intentionally provide false or untrue information.
- I understand that I must notify Florida Health Care Plan, Inc. if anything changes and is different than what I wrote on this application form. I can call 1-877-615-4022 to report any changes. I understand a change in my information could affect my eligibility.
- I confirm that I am not incarcerated (detained or jailed).
- I understand that I am applying for individual health insurance that is not intended to be a small employer health plan.
- I understand that covered services are subject to the terms in the FHCP Individual Certificate to include certain limitations, restrictions and exclusions.

X _____ _____

APPLICANT'S SIGNATURE DATE

PART 5: FHCP SALES SPECIALIST, AGENT, BROKER, NAVIGATOR & PERSONAL ASSISTANT INFORMATION

- I acknowledge that the individual named below spoke with me personally and explained the exclusions and limitations of the plan I purchased in Part 3 of this application.

X _____ _____

APPLICANT'S SIGNATURE DATE

☐ **FHCP SALES SPECIALIST:** _____
Printed Name

☐ **AGENT/BROKER:** _____ _____
Printed Name Agent License #

_____ _____
AGENT SIGNATURE DATE

☐ **NAVIGATOR/PERSONAL ASSISTOR:**

_____ _____
Printed Name Organization Name

_____ _____
Telephone Number Email

_____ _____
NAVIGATOR/PA SIGNATURE DATE