LARGE EMPLOYER APPLICATION AMENDMENT

I. Application Information

A. Group Name (from current application): ______________________________ Group #: ____________

B. Applicant hereby applies for an Amendment to the Group Policy that is currently issued by Florida Health Care Plan, Inc. d/b/a Florida Health Care Plans ("FHCP"). Upon acceptance of this amendment by FHCP, it will become part of the Policy issued to the applicant named above.

C. The requested effective date of the following amendment(s) to the current policy shall be: ____________________

II. Requested Amendment(s) to the Current Policy

☐ **A.** Change: Group Name or Affiliate Name
☐ **B.** Change: Subsidiaries, Divisions or Affiliates to be Covered
☐ **C.** Change: Waiting Period
☐ **D.** Change: Employer Contribution
☐ **E.** Change: Domestic Partner Coverage
☐ **F.** Change: Health Plan (Product)
☐ **G.** Change: COBRA Administration
☐ **H.** Change: Agent of Record
☐ **I.** Change: Other

COMPLETE ONLY THOSE SECTIONS RELEVANT TO THE REQUESTED AMENDMENT(S) TO YOUR CURRENT POLICY.

III. Amendments

A. Change: Group Name or Affiliate Name

Old Group Name ______________________________ New Group Name ______________________

Old Affiliate Name ____________________________ New Affiliate Name ____________________

B. Change: Subsidiary, Division or Affiliate to be Covered

Name ____

Address ____

Nature of Business _____________________________________ Tax ID ______________

C. Change: Waiting Period

Employee Classification Name (Ex. Full-Time employees) ______________________________

Waiting Period Duration: (Number of days new hires must wait before they are eligible to enroll)	**Add New Employees On:** (New hires will be added to the policy after satisfying the waiting period based on this selection)	**Terminate Employees On:** (Terminated employees will be canceled based on this selection)
☐ 0 Days (no waiting period) ☐ 60 Days	☐ Immediately	☐ Date of Termination
☐ 30 Days ☐ 90 Days	☐ 1st Day of Billing Cycle	☐ Last Day of Billing Cycle

Coverage for new eligible employees may be effective as selected above, so long as the eligible employee submits an application to FHCP within 30 days of the date the individual first meets the applicable eligibility requirements.

D. Change: Employer Contribution

Employer Contribution Percentage: Employees: ____________ Dependents: ____________

E. Change: Domestic Partner Coverage

Domestic Partner coverage is added to the health plan coverage. ☐ YES: Choose from list ☐ NO

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F. Change: Health Plan (Product)

Plan Benefit Period: ☐ Calendar Year ☐ Non-Calendar Year From: ____________________ To: ____________________

Health Plan Name:______________________________ Rx Option (indicate copayments) __________________________________

Employee: ___________ Employee/Spouse: ________ Employee/Child(ren): ______ Family: ________ Employee +One: _______

Fill out this row only if the health plan has split contract rating. Spouse: ____________ Child(ren): ______ Spouse/Child(ren): ______

G. COBRA Administrator Information:

Group is waiving COBRA Administration Services through FHCP: ☐ YES ☐ NO

H. Agent of Record

Agent Name: _____________________________________ Florida Insurance License Number: _________________________

Are you appointed with Florida Blue (BCBSFL)? ☐ YES ☐ NO What is your FL Blue Agent of Record (AOR) Number? ______________

I. Change: Other

Please specify details of change:

IV. Applicant Responsibilities

I understand that this information will be used to determine my group's compliance with FHCP's eligibility and Underwriting Guidelines, as well as applicability of State and Federal laws relating to my group and plan. Florida Health Care Plans reserves the right to request a UCT-6 or other documentation as evidence of business activity at any time and from time to time in order to validate compliance with eligibility and Underwriting Guidelines, as well as validate the applicability of State and Federal laws.

Upon acceptance for coverage, this amendment will become a part of the Group Policy issued, along with the Group Application. The applicant certifies the information contained in this amendment is true and complete and acknowledges that if a misrepresentation was made regarding eligibility, this coverage may be canceled or rescinded. The applicant understands 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.

Final Premiums, Benefits and Effective Dates are Subject to Approval by Florida Health Care Plans Corporate Headquarters. Issuance of the policy by Florida Health Care Plans will be deemed acceptance of this amendment.

_______________________________________ ___________ ____________________________________

Name and Title of Applicant Date Signature of Applicant

_______________________________________ ___________ ____________________________________

Agent or Sales Rep License Identification Number Date Signature of Agent or Sales Representative

Health Insurance is offered by Florida Health Care Plan, Inc. d/b/a Florida Health Care Plans ("FHCP"). FHCP is an affiliate of Blue Cross and Blue Shield of Florida, Inc. d/b/a Florida Blue. We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, sexual identity, disability, or sex. Both companies are Independent Licensees of the Blue Cross and Blue Shield Association.