EMPLOYER APPLICATION

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

GROUP # _____ COMMISSION: ☐ YES

EFFECTIVE DATE: ☐ NO

PART 1: EMPLOYER GROUP INFORMATION

FEDERAL EMPLOYER ID #:

EMPLOYER GROUP NAME (full and complete legal name):

DOING BUSINESS AS (if applicable):

NATURE OF BUSINESS:

SIC CODE:

PHYSICAL ADDRESS:

Street City County State ZIP

MAILING ADDRESS (if different from above):

Street City County State ZIP

DECISION MAKER:

Email: _____

Phone: _____

FAX: _____

Name and Title (printed)

PREFERRED WRITTEN OR SPOKEN LANGUAGE (if not English):

CONTACT PERSON

Email: _____

Phone: _____

FAX: _____

Name and Title (printed)

PREFERRED WRITTEN OR SPOKEN LANGUAGE (if not English):

EMPLOYER CLASSIFICATION:

Group Size:

☐ 1 - 3 Eligible
☐ 4 - 50 Eligible
☐ 51+ Eligible

Tax Filing Status:

☐ Sole Proprietor
☐ Corporation
☐ Partnership
☐ Other

Section 125 ?

☐ Yes
☐ No

Current Health Carrier:

Worker's Compensation Carrier:

Effective Date Term Date

PART 2: EMPLOYEE PARTICIPATION AND ELIGIBILITY INFORMATION

Average total # of ALL employees for last year: _____
(include FT, PT and Seasonal employees)

New Employee Eligibility Date:
☐ 1st of the month following wait period
☐ Date of Hire

Waiting Period:
☐ 0 Days
☐ 30 Days
☐ 60 Days

Current Total # of Employees: _____

[subtract] # of PT/Seasonal: _____

[subtract] # of COBRA: _____

[subtract] # Waiving Coverage: _____

[subtract] # in Wait Period: _____

SUBTOTAL: _____

Employer Contribution:

_____ % - Employee Coverage

_____ % - Dependent Coverage

PLAN(s) CHOSEN:

Plan Code: _____ # Enrolled _____ Plan Code: _____ # Enrolled _____

Plan Code: _____ # Enrolled _____ Plan Code: _____ # Enrolled _____

Plan Code: _____ # Enrolled _____ Plan Code: _____ # Enrolled _____

TOTAL ENROLLED: DIVIDED BY SUBTOTAL: EQUALS % PARTICIPATION **

***** Small Groups (1 - 50 Eligible) MUST have 70% participation. If a small group fails to meet this requirement, FHCP will ONLY accept the application between 11/15 and 12/15 for a January 1st effective date. Large groups (51+) must have 50%***

RIDERS CHOSEN: ☐ **Dental** ☐ **Vision** ☐ **Preferred Fitness (Gym)** ☐ **WorkForce Wellness** * (LG Group ONLY)

Conexis COBRA: (20+ EEs) ☐ Yes ☐ No Waiving Conexis COBRA: ☐ Yes ☐ No

PART 3: BROKER/AGENT INFORMATION

INDIVIDUAL Agent Information:

Printed Name Email Address FL License # & NPN Phone Number

EMPLOYER AGENCY (IF COMMISSION PAID TO ENTITY):

FLORIDA BLUE AGENT #: _____

_____ _____

SIGNATURE DATE

PART 4: EMPLOYER CERTIFICATION AND SIGNATURE

The Employer named above hereby applies for Employer Group Health Benefits Plan membership in Florida Health Care Plans (FHCP) on behalf of its eligible members and their eligible dependents who elect to enroll in FHCP. If accepted, this Employer Application, Employee Enrollment Forms, Executed FHCP FHCP Employer Group Health Benefit Plan Contract, Schedule of Benefits, Summary of Benefits and Certificates of Coverage for the benefit plan constitute the entire Contract between the Group and FHCP. The Employer agrees to pay any and all monthly subscription fees associated with the coverage chosen for their employees and, if applicable, dependents. The Employer certifies that it is a group employer and eligible for coverage under the applicable section of the Florida Statutes and relevant law and approved by the Department of Financial Services and any other applicable government agencies. Employer certifies that an authorized representative has read the states on this form or that they have been read to the authorized representative and that all the information provided is true and complete to the best of knowledge. It is understood that any material misrepresentation or material omission contained herein may be used to reduce or deny a claim or service or to void the Contract. It is understood that no agent can modify this application, waive the answers to any questions, or suggest or complete the answers thereto. ANY PERSON WHO KNOWLINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM OR ANY APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

_____

COMPANY NAME (please print)

_____ _____

AUTHORIZED REPRESENTATIVE (please print) TITLE

_____ _____

SIGNATURE DATE

FHCP - 43, Rev. 6/2017