

## HEALTH CHOICES: FLORIDA'S INSURANCE MARKETPLACE EMPLOYER QUESTIONNAIRE

Group's Legal Name				
Group Name to appear on ID card <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>				
Address				Tax ID
City	State	Zip Code	Names of Owners/Partners (if applicable)	
Contact Person	Telephone		Fax	Email Address
Billing Address (If Different)				# of Years in Business
Organization Type <input type="checkbox"/> Partnership <input type="checkbox"/> C-Corp <input type="checkbox"/> S-Corp <input type="checkbox"/> LLC/LLP <input type="checkbox"/> Ind. Contractor <input type="checkbox"/> Non-Profit <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other _____			Nature of Business	Industry (SIC) Code
Employer Contribution: _____ % Or \$_____ per employee	Waiting Period for new hires: ___ No waiting period      ___ One month after hire date ___ Two months after hire date      ___ Three months after hire date			
Have Worker's Comp <input type="checkbox"/> Yes <input type="checkbox"/> No	Worker's Comp Carrier Name		Names of Owners/Partners not covered by Workers' Comp	
# Eligible Employees working in FL	# Eligible Employees working outside FL	# Ineligible Employees (Have not satisfied waiting period or work less than 25 hours per week)	# Excluded Employees (Have other group or public coverage)	# Total Employees
# Persons currently on COBRA/Continuation	Names of Persons currently on COBRA/Continuation:			
Does the group currently have health coverage? If yes, Name of Carrier is _____ Has the group had coverage in previous 12 months? If yes, Name of Carrier was _____				

### Signature Section

I understand that Florida Health Choices and participating vendors will rely on the information I provide in determining eligibility for coverage, setting premium rates, compliance with applicable laws, and other purposes, and that any material misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences. Florida Health Choices and its participating vendors reserve the right to audit and to request documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and underwriting guidelines as well as validate the applicability of State and Federal laws. I understand that my failure to comply with any such request may also result in termination of coverage, increase in premiums, or other consequences.

Employer Business Name

Date

Authorized Signature

Print Authorized Name

Agent Name

Agent Marketplace I.D.

Agent Signature

**ANY PERSON, WHO WITH INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.**