

FLORIDA HEALTH CARE PLANS GROUP EMPLOYER QUESTIONNAIRE

Group's Legal Name									
Group Name to appear on ID card (maximum 30 characters)									
<div style="display: flex; justify-content: space-between;"> <div style="width: 70%;">Address</div> <div style="width: 30%;">Tax ID</div> </div>									
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	
# Hours worked per week to be eligible		Waiting Period for new hires <input type="checkbox"/> 1st of Policy Month following Date of Hire <input type="checkbox"/> 1st of Policy Month following ____ [months] [days] of employment <input type="checkbox"/> Date of Hire (no waiting period) <input type="checkbox"/> ____ months/days of employment following Date of Hire						Waiting Period waived for initial enrollees <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer Contribution ____% Single ____% Dependent		Number of Full Time Employees		Total Employees Participating			Number of Carriers for Last 5 Years		
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					
Names of Persons currently on COBRA/Continuation:									
Has the Group been insured by FHCP in the last 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No						If yes, date coverage terminated: / /			
Name of Current Medical Carrier									
Begin Date ____/____/____				End Date ____/____/____					

The following questions must be answered thoroughly and accurately. Any ambiguity may delay approval. These questions apply to all active employees, their dependents as **well as all COBRA** participants and their dependents.

1. In the past twelve months, has any employee or dependent incurred medical claims in excess of \$10,000?
☐ Yes ☐ No
2. As of this date, are there any employees or dependents to be covered that are disabled or not working full time at 25 hours per week? ☐ Yes ☐ No
3. Have any employees been absent for seven or more days in the past twelve months due to illness or any dependents hospitalized for seven or more days in the past twelve month? ☐ Yes ☐ No
4. Are you currently aware of any chronic medical conditions (cancer, diabetes, heart, kidney, AIDS or Aids Related Complex, etc.) afflicting any employee or dependent? ☐ Yes ☐ No
5. Are any employees or dependents currently pregnant? ☐ Yes ☐ No. If yes, how many and what is the expected delivery date(s)?
7. Are there any employees who are currently on COBRA? ☐ Yes ☐ No If yes, please provide the reason for election of COBRA (i.e. between jobs, loss of dependent or student status or disability), date of onset and date of termination.

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Please provide details to all "YES" responses in the spaces provided below. Additional sheets may be used if needed.

<u>Question#</u>	<u>Date(s)</u>	<u>Diagnosis</u>	<u>Amount of Claim</u>	<u>Current Health Status</u>

Signature Section

I understand that FHCP 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. FHCP reserves 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 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.