Health First
Health Plans & Insurance

Large Group Quote Questionnaire

6450 US Highway 1, Rockledge, Florida 32955
Toll-free (800) 716-7737
www.myHFHP.org

1. Group Information

Legal name of company_____ Date business established_____

Street address_____

City_____ State_____ County_____ Zip _____

Telephone_____ Fax_____ E-mail _____

Contact person _____ Title _____

Does your company have additional locations? ___No ___Yes (If yes, please explain below:)

_____

Current carrier? _____ Anniversary date _____ How long with carrier? _____

Current rates: Employee_____ Employee + Spouse_____ Employee + Child(ren)_____ Employee + Family _____

Renewal rates: Employee_____ Employee + Spouse_____ Employee + Child(ren)_____ Employee + Family _____

Current plan design(s): ___HMO ___POS ___PPO *+++Attach current plan designs+++*

2. Eligibility/Participation

Classes of eligible employee (check all that apply):
___Active Full Time (How many hours worked per week _____)
___Part-Time (How many hours worked per week _____)
___Leave of Absence (Provide LOA Policy)
___Retiree (Provide Retirement Policy)
___Other, please describe _____

Do all eligible employees live in Brevard County or Indian River County? __Yes __No
If no, list the zip codes _____

Employer contribution: _____ Does the employer offer an incentive to waive coverage? __Yes __No

Waiting period: _____

Are any present or former employees or dependents currently on or eligible to elect continuation of coverage (COBRA)? __No __Yes
If yes, please list their names, dates they started continuation and the qualifying event:

_____

_____

Are any employees currently not actively at work, or on Leave of Absence? __No __Yes (If yes, please explain below:)

_____

Do any eligible employees or dependents spend more than 30 consecutive days outside of the Health First service area (Brevard and Indian River Counties)? __No __Yes (If yes, please provide details below:)

Provide census listing gender, date of birth and dependent status.

3. Other Required Information

Has anyone had a claim over $10,000 in the past two years? __No __Yes (If yes, provide information below)

Gender *Date of Birth* *Diagnosis* *Occurrence Date* *Claims Paid* *Prognosis*

Has anyone been treated for a serious illness, been hospitalized or had surgery in the past twelve months: __Yes __No

Does anyone have a continuing claim for an existing mental or physical disorder? __Yes __No

Has anyone been advised to have surgery in the last six months or anticipate hospitalization for any reason? __Yes __No

Is there any employee or dependent currently pregnant in the third trimester? __Yes __No

Are there any handicapped dependents over the limiting age to be covered in the group? __Yes __No

If yes, are the handicapped dependents insured by the current group plan? __Yes __No

If you answered yes to any of the above questions, please provide additional details:

4. Broker Information

Agent/Broker Name Tax ID/SS#

Agency Name Telephone Number Fax

Special considerations, if any: _____

_____

V. Applicant Certification

Applicant's Signature Applicant's Title Date

Soliciting Agent's Signature Requested Effective Date