AdventHealth Advantage Plans
Underwritten by Health First Commercial Plans

Contract ID Number:_____

Individual Coverage Application

For Off-Marketplace Plans—For New and Renewing Coverage

This application must be completed in its entirety or processing time may be delayed. Applicants must reside within the AdventHealth Advantage Plans service area to be eligible for coverage.

Send original completed application to:
AdventHealth Advantage Plans
Attention: Sales
6450 US Highway 1
Rockledge, Florida 32955

myAHplan.com
Sales Department: Toll free **1.855.737.4347**
Email: individualinsurance@hf.org ■ TDD/TTY: 1.800.955.8771
November 1–December 15: Call weekdays 8 am to 6 pm
December 16–October 31: Call weekdays 8 am to 5 pm

Application requirements and instructions

- This Application must be filled out by the Applicant. You (the Applicant) are responsible to guarantee the information provided is accurate, complete, and truthful. Failure to complete any section will result in a delay in processing your application.
- **Do not cancel any health insurance coverage you currently have or decline COBRA benefits until you receive notice of acceptance from AdventHealth Advantage Plans**. Please retain a copy of this application for your records.
- Any misrepresentation of information on the Application may result in cancellation of coverage.
- Any family member of an Applicant who is age 18 or older must also sign and date the Application.
- All eligible family members must apply on one application.
- A dependent from age 26 to age 30 must meet the eligibility requirements in accordance with Florida law.
- To obtain coverage for a member's newborn or adopted child outside of the annual open enrollment period, a policyholder must complete and submit an Individual Coverage Application or Change Form within sixty (60) days of the child's birth or placement in the home. Send the completed Application, with first month's premium payment, if applicable, to AdventHealth Advantage Plans at the address above.
- Please be advised that your quoted premium may be adjusted by AdventHealth Advantage Plans as a result of enrollment fees, billing options, benefit/plan changes, available effective dates, age/birth date, or any other relevant factors.
- AdventHealth Advantage Plans complies with all federal regulations including guarantee issue provisions as outlined in the Health Insurance Portability and Accountability Act (HIPAA), and in the Affordable Care Act (ACA).
- Please enter your benefit plan selection in Section 3 of the Application.
- All information is confidential.
- The Open Enrollment Period, or yearly period when people can enroll in a health insurance plan or make changes, runs from November 1st through January 15th.

Must be completed in blue or black ink.

Section 1: PRIMARY APPLICANT INFORMATION

Primary Applicant's Name/Last			First		M.I.
Marital Status ☐ Single ☐ Married			Language		
Home Address *(No P.O. Box):* Street		Apt.	City	State	Zip
Home phone ( )	Work phone ( )	Cell phone ( )	Other ( )	Best time to call ☐ AM ☐ PM ☐ Any	

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E-mail address _____ *By providing my email address, I am authorizing AdventHealth Advantage Plans to send any and all communications regarding this Application via secure email.*

Section 2: ADDITIONAL APPLICANT INFORMATION

	Sex	Name (Last, First, MI)	US citizen?	Social Security Number	Date of Birth (MM/DD/YYYY)	Tobacco use in the past 6 months?
1	M / F	Primary Applicant	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __ /__ __ __ __	Yes / No
2	M / F	Spouse	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __ /__ __ __ __	Yes / No
3	M / F	Dependent Child	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __ /__ __ __ __	Yes / No
4	M / F	Dependent Child	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __ /__ __ __ __	Yes / No
5	M / F	Dependent Child	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __ /__ __ __ __	Yes / No
6	M / F	Dependent Child	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __ /__ __ __ __	Yes / No
7	M / F	Child of Dependent Child	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __ /__ __ __ __	Yes / No
8	M / F	Child of Dependent Child	Yes / No	__ __ __ -__ __-__ __ __ __	__ __/__ __ /__ __ __ __	Yes / No

I attest that the children listed on this application are my legal dependents. Initial _____

Section 3: PLAN SELECTION

Medical plan—All medical plans are compliant with the Affordable Care Act and cover all required Essential Health Benefits, including Pediatric Dental and Vision. Please mark your plan choice:

Plan name:_____ Plan number (4 digits): __ __ __ __
(For example "AdventHealth Bronze HMO 60") *(For example "1752")*

Requested effective date *(AdventHealth Advantage Plans will attempt to provide you with the requested effective date, however, the requested effective date is not guaranteed.)*

__Jan. __Feb. __Mar. __April __May __June __July __Aug. __Sept. __Oct. __Nov. __Dec.

Section 4: PRIOR/OTHER COVERAGE *Optional for renewing members*

A. Have you or any Applicant ever been a member of an individual or group plan with AdventHealth Advantage Plans? ☐ Yes ☐ No
If yes, please provide the member's name and Policy number:

_____

_____

B. Do you or any applicant have health insurance coverage which ended within the last 60 days? ☐ Yes ☐ No
If yes, please provide Applicant's name, insurance company's information, type of coverage, effective date, and termination date:

_____

_____

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C. Do you or any applicant currently have health insurance coverage?

Complete this section only if you or any of your dependents have other health coverage that will not be cancelled when the coverage under this application becomes effective. List names of each individual covered. If you and/or your dependents will not have other coverage, please initial _____.

Group Coverage __Yes __No	Name and Address of Other Insurance Carrier		
Effective Date (MM/DD/YYYY)	Type of Policy __Employee Only __Employee/Spouse __Employee/Child(ren) __Family		
Name of Policyholder (First, Last)		Birth Date (MM/DD/YYYY)	__Male __Female
Relationship to Applicant __Self __Spouse __Dependent	Employer's Name		Coverage Start Date (MM/DD/YYYY)
Group Number	Policy Number		

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name & Date of Birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B" when this dependent is covered under both you and your spouse's insurance plan (married).
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

I understand 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. **Initial**_____

Section 5: CONDITIONS of ENROLLMENT Please carefully read the information below.

GENERAL CONDITIONS: Coverage will only apply to services provided on or after the effective date of coverage.

PAYMENT OF PREMIUM: Please note that this coverage is not to be sold as a commercial group policy. If accepted for coverage, each Applicant is responsible for the initial premium as well as any future payments. If funds are drawn from a business account, I certify that I am the business owner and the payments are for myself and/or other Applicants as individuals and not as employees. I understand that payments from a business account are not for employees or others outside of my immediate family. Refund of premium is only payable to the primary Applicant. If your policy terminates due to non-payment of premium, AdventHealth Advantage Plans has the right to apply to any past-due premium amounts owed, the initial premium payment made for new coverage within the 12-month period and past-due balances accumulated within the previous 12-month period prior to the coverage start date may be required before any new coverage commences.

BINDING AGREEMENT: The applicable AdventHealth Advantage Plans Certificate of Coverage and this Application, (collectively the "Contract"), shall constitute the entire agreement between the Applicant(s) and AdventHealth Advantage Plans. The Applicant(s) hereby agree to be bound by the terms and conditions as set forth in the Contract if accepted for coverage in accordance herewith. **PLEASE RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS.**

The Applicant's signature below shall constitute acceptance of the Contract on behalf of such Applicant and the primary Applicant's signature shall constitute acceptance of the Contract for any Dependent Applicant(s) who are under the age of 18, as listed in Section 2 above.

I hereby agree that the Contract shall automatically renew on January 1 of each year and any benefit changes required to comply with the Affordable Care Act or state statutes will be included as of that effective date subject to any and all amendments to the Contract, including rate or benefit changes, as determined by AdventHealth Advantage Plans or elected by me on behalf of myself and all Applicants, without my express consent unless I, any Applicant, or AdventHealth Advantage Plans determines to terminate the Contract in accordance with its terms.

OMISSION CLAUSE: I represent that all statements and answers made in this document, by whomsoever written including its reverse side and on any attached papers, are complete, true and correct to the best of my knowledge. I agree that this shall be the basis of my and all Applicants' acceptance of enrollment with AdventHealth Advantage Plans. I understand

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that AdventHealth Advantage Plans will rescind coverage only due to an act or practice constituting fraud or an intentional misrepresentation of a material fact.

COUNTERPARTS: This Application may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall constitute a single agreement.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *Please review it carefully*.

HIPAA Privacy Rule requires healthcare providers and health plans to develop and distribute a notice that provides a clear, user-friendly explanation of customers' rights with respect to their personal health information and the privacy practices related to that information.

Our Pledge

This notice applies to all customers receiving services from Health First, Inc., Health First Medical Group, LLC, Health First Privia Medical Group, LLC[1] and/or Health Plan[2]. Health First is committed to improving the wellness and health of our customers and community. We want you, our customers, to feel supported and informed about your care and coverage. This includes explaining how we use, manage and safeguard your information and your rights and choices related to your information.

If you have any questions about this notice, please contact the Health First Privacy Office at ***321.434.7543****.*

Your Information

In this notice, information refers to any information that identifies you, as a current or former Health First customer, and relates to your health or condition, your healthcare services, payment or coverage for those services. It includes claims and coverage information, and health information, like diagnosis and services you received. It includes demographic information like your name, address, phone number and date of birth. It includes information that comes from you or results from you doing business with us, our affiliates or others, such as enrollment, prior approvals, referrals, coverage determinations, claims and payment information.

How we safeguard your information

We allow access to your information by our workforce members but only to the extent they need that information for treatment, payment, healthcare operations and/or to administer your health plan and benefits, comply with legal or accreditation requirements, or as otherwise allowed by law. As such, and in order to provide our customers with necessary, appropriate, and timely continuity of care, Health First entities have several electronic platforms, systems, and applications that share your information throughout our Integrated Delivery Network ("IDN") and the community where needed and permitted for treatment, payment and healthcare operations and in accordance with applicable law.

We maintain physical, electronic and administrative safeguards designed to protect your information and prevent unauthorized access.

How do we typically use and share your information?

We may share your information without your written authorization for the following purposes:

For Treatment:
To share with healthcare providers (doctors, dentists, pharmacies, hospitals and other caregivers) for your treatment or to coordinate preventative health, early detection and disease and case management programs.

Example: Your doctor sends us information about your diagnosis and treatment plan so we can help arrange for additional services.

Please note, that we do not need your permission to share your information in a medical emergency, if you are unable to give us permission due to your condition. Also, the organizations covered by this notice do not need your permission to share your information with each other, as long as it is for a permitted purpose.

For Payment:
To pay or receive payments for care that you receive.

Example: We may contact your providers to coordinate your benefits and to confirm eligibility and coverage or we might contact your health plan to pay for services you received at our facilities.

For Healthcare Operations:
To support daily business activities for healthcare operations.

Example: We use and disclose your information to tell you about plan benefits, treatment alternatives or health-related products and services. We use your information for quality management, improvement activities, care coordination and for underwriting purposes. We also use your information to contact you regarding your appointments or for fundraising

activities. If you do not want to be contacted by Health First for fundraising efforts, you must notify the Health First Foundation in writing at **ATTN: Foundation Gift and Data Specialist, 1350 S. Hickory St., Melbourne, FL 32901** or by phone at **321.434.7353**.

Unless you tell us otherwise, we may include some limited information about you in our directory. This information might include your name, location and general condition. We might share this information with your family members and friends unless you tell us otherwise.

To administer your plan:
We may share your information with our affiliates (also known as related organizations) that help us administer and manage our health plan. We may also share your information with non-affiliated (non-related) third parties permitted by HIPAA. These organizations are generally known as Business Associates. Health First contracts with these Business Associates to provide certain products or services on our behalf. Business Associates are required by law to safeguard your information the same way we do.

Other uses and disclosures:
We may also share your information with other third parties, including regulatory authorities, government agencies or law enforcement, as allowed or required by law.

The Health Plan in providing fully insured benefits to a group health plan, or helping administer the benefits of a self-insured group health plan, may, if requested, share limited information with the sponsor of your group health plan, for plan administration purposes, if certain privacy requirements are met.

Example: For a fully insured plan, the Health Plan may share certain statistics with your employer to explain the premiums we charge.

We use or share your information if state or federal law requires it.

Public health and safety issues:
We share your information with public health authorities or other authorized agencies in certain situations such as:

- Prevent disease
- Help with product recalls
- Report adverse reactions to medications
- Report suspected abuse, neglect, domestic violence or crimes in our care locations
- Prevent or reduce a serious threat to anyone's health or safety
- Help with health system oversight, such as audits or investigations
- Comply with special government functions such as military, national security, presidential protective services and disclosures to correctional facilities.

Respond to organ and tissue donation requests: We use and share your information to help with organ or tissue donation.

Work with a medical examiner or funeral director: We share your information with a coroner, medical examiner or funeral director.

Handle workers' compensation:
We use and share your information for your workers' compensation claims.

Respond to lawsuits and legal actions:
We can use and share your information for legal actions, or in response to a court or administrative order, or other lawful process. We can share your information with authorized law enforcement officials.

Organized Health Care Arrangement (OHCA)
Health Plan participates in two distinct Organized Health Care Arrangements (OHCA) under the Health Insurance Portability and Accountability Act (HIPAA). An OHCA is an arrangement that allows covered entities, which are a healthcare provider, health plan or healthcare clearinghouse, to share Protected Health Information (PHI) about their customers, person receiving services, or plan members to provide healthcare services, to perform payment and to perform healthcare operations. Health Plan participates in one OHCA with AdventHealth and its Florida-based affiliates. Health Plan also participates in a separate OHCA with other Health First, Inc. entities. Please contact our Privacy Office if you would like to know what networks or accountable care organizations Health Plan participates in.

Uses and disclosures that require your authorization:
For any other purposes not described in this document, we must obtain your written authorization to use or share your information. For example, we would need your authorization:

- For uses and disclosures of psychotherapy notes.
- To use your information for marketing purposes for which financial payment is received.
- For any sale involving your information resulting in financial or non financial payment.

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Your Individual Rights:
You have certain rights regarding information that Health First creates, obtains or maintains about you. To exercise these rights, please contact us at the location below:

Health First
Health Information Management Department
3300 S. Fiske Blvd., Building B
Rockledge, FL 32955

Review or get a copy of your information You can ask to see or get a copy of your information stored in paper or electronic records. We will provide a copy or a summary of your information. If there are records that we cannot share or if we need to limit access, we will inform you as to this fact. We may charge a fee to process your request.

Ask us to correct your information (Amendment)
You can ask us in writing to correct your information if you feel that it is incorrect or incomplete. We will correct the information if allowed by law. We may say "no" to your request, but we will explain the reason in writing. If your request is denied, you can ask us to keep a copy of your disagreement (a written statement you provide to us) with your records.

Ask us to limit what we use or share (Restriction)
You can ask us in writing not to use or share your information. We will always consider your request, but we may say "no" if it would affect our ability to provide care or service to you or cause a customer safety concern. If we agree to the restrictions, we will abide by them.

Request confidential communications
You can ask us in writing to contact you in a specific way or at a specific location (for example, home or office phone). We will not ask you the reason of your request and we will accommodate all reasonable requests.

For Health Plan customers: If you notify us that a possible communication could endanger you, we must accommodate your reasonable request for confidential communications.

Get a list of who has received your information (Accounting of Disclosures) You can ask us for a list of the times we have shared your information with outside organizations or customers, who we shared it with, and why. Your request must be in writing and must include a specific time period.

We will include any disclosure that occurred within the last six years of your request, where we have shared your information, except for when it was about your treatment, payment for your treatment or health care operations. We will provide you with the date of disclosure, the name of the entity or person who received the information and a brief description of the information disclosed.

Get a copy of this notice
We reserve the right to change this notice. The changes will apply to all information we have about you. If we make any changes, we will post the new notice at all Health First locations and websites. We will provide a current copy to you upon enrollment, annually and when you receive services at any Health First entity. Health Plan customers, however, will receive this notice upon enrollment and no less frequently than once every three years. Unless you are a Health Plan customer, we are required to ask you to sign an acknowledgment that you have received this notice.

You can ask for a paper copy of this notice at any time even if you agreed to receive this notice electronically. We will provide it as requested.

We may provide this notice to you by email if you have agreed to receive electronic notification. We are required by law to follow the privacy notice that is in effect at this time. This notice is also available on our website at HF.org.

File a complaint if you feel your privacy rights have been violated
You can complain directly to us if you feel we have violated your privacy rights by contacting us using the information available at the end of this notice. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. Find contact information at *www.hhs.gov/ocr/privacy/hipaa/ complaints*. We won't retaliate against you for making a complaint.

Your Choices
In some situations, you have additional choices about how we use and share your information. If you have a preference in the situations described in this document, let us know. Tell us what you want us to do, and we will follow your instructions while following the law.

You can tell us not to:
Share your information with your family, close friends or others involved in your care or payment for your care.

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You can also tell us not to share your information with others for health research (we can still use your information for our own research as long as we follow the law).

Our Responsibilities:

- We protect your information because your privacy is important to us, and because it is the law.
- We must follow the responsibilities and privacy practices described in this notice.
- We must make this notice available to you when you become a customer and must post it online at HF.org
- We will let you know in accordance with the law if a breach (unauthorized access, use or sharing) occurs that may have put the privacy of your information at risk.
- We will not use or share your information except as covered in this notice, unless you tell us we can in writing. You may revoke your authorization at any time. Let us know in writing if you change your mind.
- When the law requires us to get your permission in writing before we use or share your information, we will do so.
- We will not use your genetic information to decide whether we will give you coverage and the price of that coverage.

Health Information Exchange Opt-Out-
Health First Medical Group, LLC and Health First Privia Medical Group, LLC ONLY

Health First Privia Medical Group, LLC participates in a Health Information Exchange ("HIE"). You have the right to opt out of disclosure of your medical records to or via an electronic health information exchange ("HIE"). However information that is sent to or via an HIE prior to processing your opt-out may continue to be maintained by and be accessible through the HIE. You must opt out of disclosures to or via an HIE through each of your individual treating providers who may participate in any given HIE. To opt out, you will need to fill out the Health First Privia Medical Group, LLC HIE Opt-Out Request Form ("Request Form") and/ or contact the HIE directly. To receive a Request Form or for other information regarding the HIE, please contact your Health First Medical Group, LLC or Health First Privia Medical Group, LLC physician office. If you decide later on that you want to opt back into the HIE, you may do so by submitting the Health First Privia Medical Group, LLC Reinstatement of Participation Form ("Reinstatement Form"). To receive a Reinstatement Form, please contact your Health First Medical Group, LLC or Health First Privia Medical Group, LLC physician office.

In addition to contacting your physician office, if you have questions regarding the HIE or to receive the Request Form or the Reinstatement Form, you can email privacy@priviahealth.com. Additionally, to opt out of the HIE, please email medicalrecords@priviahealth.com.

For information, questions or complaints You may get more information about our privacy practices and your privacy rights by calling Health First Chief Privacy Officer at 321.434.7543. You can also find this information online at HF.org. You can also contact the Health First HIPAA and Compliance Hotline at 1.888.400.4512.

Effective: April 1, 2003
Revised: July 2016, October 2019, January 2020

[1]Health First Privia Medical Group, LLC is a Limited Liability Company attached to the Health First, Inc. IDN but is owned by community physicians.

[2]For the purpose of this notice, Health First Health Plans, Inc., Health First Administrative Plans, Inc., Health First Commercial Plans, Inc., Health First Insurance, Inc., and AdventHealth Advantage Plans are herein referred to as "Health Plan."

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ACKNOWLEDGEMENT and AGREEMENT: I understand and agree to abide by all terms, conditions and provisions of the Contract. I have read and understand this Application including the conditions of enrollment. I understand if this Application is accepted it will become part of the Contract. My signature (either signed below or electronically submitted) indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct.

❑ By checking this box and entering my name and date below, I am indicating my intent to electronically sign this Application and warrant that all of the information I have provided is true, complete, and accurate. I acknowledge having been provided the required forms during the application process.

Print Name		**Date**		**X**	
	Primary Applicant				Signature of Primary Applicant
Print Name		**Date**		**X**	
	Spouse (if applying for coverage)				Signature of Spouse
Print Name		**Date**		**X**	
	Dependent (Required if age 18 or older)				Signature of Dependent
Print Name		**Date**		**X**	
	Dependent (Required if age 18 or older)				Signature of Dependent
Print Name		**Date**		**X**	
	Dependent (Required if age 18 or older)				Signature of Dependent
Print Name		**Date**		**X**	
	Dependent (Required if age 18 or older)				Signature of Dependent

Section 6: ACKNOWLEDGEMENT

IT IS IMPORTANT YOU REVIEW AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By submitting an application for benefits, I agree with all of the statements listed below:

- I attest the information submitted in this Application is true and accurate to the best of my knowledge. 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.
- Once benefits are effective, they are contingent on timely and accurate payment of premiums and any other cost sharing as outlined in the policy. If payment is not accurate and paid on time, my coverage will be terminated. If terminated for non-payment, I may no longer be eligible to enroll in AdventHealth Advantage Plan.

Authorization for electronic signature

❑ By checking this box and entering my name below, I am indicating my intent to electronically sign this Application and warrant that all of the information I have provided is true, complete, and accurate. I acknowledge having been provided the required forms during the application process.

Primary Applicant First Name | Primary Applicant Last Name | Date

Section 7: STATEMENT of ACCOUNTABILITY *Complete if the Applicant cannot or has not completed the application.*

I have personally read and completed the Individual Application for the applicant because:

- Applicant is a minor and I am the applicant's parent or legal guardian.
- Applicant has limited English proficiency and is unable to complete this application.
- The Applicant is legally incapacitated and unable to complete this application.

I have read and explained in detail the contents of this application. If translated, I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal information disclosed by _____.

Proxy/Translator's Name (please print) **Date:** **X** Proxy/Translator's Signature

Section 8: INSURANCE PRODUCER INFORMATION

I have read the Application and all questions have been answered in full. **Incomplete Applications will be returned.** I verify that the Applicant has either physically or electronically signed this Application. Initials: _____

Agency Name:

Agency Address:

Street/Suite No. City State Zip

Agent Name: Print Date **X** Signature

Phone Number: Fax: Email address:

NPN#: Agent License Number:

Section 9: HEALTH PLAN REPRESENTATIVE INFORMATION (for Internal use only)

Print Name: Last First

X Signature **Date:**

NPN#: Agent License Number:

AdventHealth Advantage Plans is underwritten by Health First Commercial Plans, Inc. Health First Commercial Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations. AdventHealth Advantage Plans agrees never to sell your information. By submitting your email address, you expressly agree to receive promotional information from AdventHealth Advantage Plans, subcontractors and their affiliates regarding information, events, promotions, specials and patient satisfaction surveys. You also understand that you have the right to "opt out" at any time through request in a reply to the email.