Health First
Health Plans

6450 US Highway 1
Rockledge, FL 32955

Customer Service
Telephone 321.434.5665
Toll-free 800.716.7737
TDD relay 800.955.8771
E-mail hfhpinfo@health-first.org

Participation Verification

Group name: _____
Group number: _____

Please complete the following information listing all current employees. The Employer Group Application allows us to request this information, which we review for eligibility and participation requirements. ***We must have this information before we can process new and renewal business.***

1. Total number of employees currently on your payroll: _____
2. List information on all employees of your organization (including owners if appropriate):
   - If employee is part-time, include hours worked per week.
   - If employee is listed in the waiting period, include date of hire and hours worked per week.
   - If employee is terminated, include the employee's termination date.

Employee Name	**Social Security No.**	**Hours worked per week**	**Status** (write number: 1=Electing / 2=Waiving *with* other coverage / 3=Waiving with *no* other coverage / 4=Waiting period / 5=Part time)	**Hire / termination date** (mark H or T with date)

Employer Certification: I hereby represent that I have reviewed our employee records and that the above information is complete and accurate. I further represent that no person is insured under this plan except for eligible employees and their dependents. I understand these representations will be used in evaluating our company's eligibility to participate in the insurance coverage through Health First Health Plans. I further understand omissions, misrepresentations, or misstatements could result in claim denial or termination of insurance. In addition, I understand that Health First Health Plans reserves the right to request appropriate tax documentation (ie, State Wage & Tax Report) to confirm the information stated above and verify participation and eligibility.

Signature of Company Officer **Date**