

Common Ownership

Please have this form completed and signed by an Authorized Representative of the Company.

_Group # _____

Legal Name of Group

	ce Portability and Accountability der subsection (b), (c), (m), or (comployer.	· · · · · · · · · · · · · · · · · · ·	•
	anies that would qualify as one ode. Attach separate sheet, if a v, sign & date.		
Business Name	Employer Identification Number	Total Average Number of Employees in Preceding Calendar Year	Total Number of Employees on Payroll
Legal Name of Group			
Affiliate			
Affiliate			
Affiliate			
Grand Total			
certify that the applicant is a single employer under section 414 of Internal Revenue Code of 1986 (26 U.S.C. § 414 (b), (c), (m), or (o)), and under any applicable state law. 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 elony of the third degree.			
elony of the third o	legree.		
Date S	gnature of Group Representative		Relationship to Company
Date F	lorida Health Care Plan, Inc. Licensed Agent		Print/Type Name & Title
lealth Insurance is offe	ared by Florida Health Care Plan Inc. [7/R/A Florida Health Care Plans (Fl	ICP) is a subsidiary of Blue Cross

and Blue Shield of Florida (BCBSF). FHCP and BCBSF are Independent Licensees of the Blue Cross and Blue Shield Association.