Employee Enrollment Form

AvMed HEALTH PLANS

Coverage Type: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child ☐ Employee + Children ☐ Family

Plan Option: ☐ HMO ☐ POS ☐ Choice ☐ HDHP ☐ HDHP with HSA ☐ CDHP ☐ HRA ☐ Other _____

*HSA and HRA, administered by HealthEquity

Employer Information

Employer Name | Group/Division# | Date of Hire | Employee Effective Date of Coverage

Employee Work Status: ☐ Active ☐ Retired **If COBRA status DO NOT CONTINUE** - employee must fill out a separate COBRA application

Employee Information

Last Name | First Name | M.I. | Social Security | Birth Date | Male or Female

Street Address | Apt. # | City | State | Zip

☐ single ☐ married

Home Phone | Work Phone | Occupation | Marital Status

Ethnicity (optional) See legend below | Preferred Language (optional) | AvMed PCP Name / PCP #

Are you covered by Medicare? ☐ Yes ☐ No If yes, why? ☐ 65+ ☐ Disabled

Dependent Information (Attach separate sheet with dependent information if additional space is needed, sign and date)

Relationship? See Legend below	Last Name	First Name, M.I.	SS#	Birth Date	Male or Female	AvMed PCP Name / PCP #	Ethnicity (optional) See Legend Below

Relation to You: **SP** = Spouse, **DP** = Domestic Partner, **CH** = Child, **SC** = Stepchild, **GC** = Grandchild

Ethnicity: **1)** African American **2)** American Indian **3)** Asian **4)** Black **5)** Hispanic/Latino **6)** White **7)** Other

If you are married, is your spouse currently employed?

☐ Yes ☐ No

Spouse's Employer:

Is your spouse covered by another health carrier?

☐ Yes ☐ No

Name of spouse's health plan:

Is your spouse covered by Medicare? ☐ Yes ☐ No *If yes, why?* ☐ 65+ ☐ Disabled

NOTE: All eligible dependent children must meet eligibility requirements as defined in the Group Contract and the Employee must provide proof of such status for the dependent children to be eligible for coverage up to the maximum age specified. If dependents have different last names than that of the employee, attach copies of legal supporting documents as evidence of their dependent status.

EMPLOYEE MUST SIGN AND DATE THE FOLLOWING CERTIFICATION AND AUTHORIZATION: I hereby request to participate under my Employer's Group Plan. This request and all elections and authorizations shall remain in effect until I change them in writing. I authorize my employer to deduct from my earnings any required contribution for the requested coverage. I certify that all information supplied on this form is true to the best of my knowledge. I understand that all benefits for myself and my eligible dependents will be provided in accordance with the plan. I agree to abide by the terms and conditions governing membership and receipt of health services in the plan. I have read and agree to the terms and conditions as outlined below. I understand that, under Florida law, **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.**

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical facility, insurance or reinsuring company to disclose to AvMed Health Plans, any and all such information related to me or my dependents, provided such records were established while enrolled with AvMed. This authorization includes psychiatric and substance abuse records as well as concurrent inpatient review.

I understand that any dispute with AvMed Health Plans shall be subject to the Grievance Procedure in accordance with the provisions of the Group Medical and Hospital Service Contract.

I understand that AvMed's documents (Certificate of Coverage, Summary Plan Description, Amendments, and Schedule of Benefits) will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.

Employee Signature	Date: / /
Employer/Administrator Signature	Date: / /