Employee Enrollment Form

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

Plan Option

Plan type:__________________ Plan Number:__________________ Group Number:__________________

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

*Please check your specific plan design to determine if you are required to choose a PCP.

Last Name | First Name | M.I. | Social Security | Birth Date | Gender (☐ Male ☐ Female)

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

Home Phone | Work Phone | Occupation | Marital Status (☐ Single ☐ Married)

Email | Preferred Language (optional) | Ethnicity** | AvMed PCP/PCP#*

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

Tobacco Use: ☐ Yes ☐ No

Dependent Information

*Please check your specific plan design to determine if you are required to choose a PCP.
(Space for additional dependent information on second page of this application.)

Relationship (see legend below) | Last Name | First Name | M.I.

Social Security | Birth Date | Gender (☐ Male ☐ Female) | Tobacco Use (☐ Yes ☐ No)

Ethnicity** | Email | AvMed PCP/PCP#* | Current Patient? (☐ Yes ☐ No) | Are you Disabled? (☐ Yes ☐ No)

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? ☐ Age 65+ ☐ Disabled

Employee Enrollment Form

Additional Dependent Information *Please check your specific plan design to determine if you are required to choose a PCP.

Relationship (see legend below)	Last Name	First Name	M.I.
Social Security	Birth Date	☐ Male ☐ Female Gender	☐ Yes ☐ No Tobacco Use

Ethnicity**	Email	AvMed PCP/PCP#*	☐ Yes ☐ No Current Patient?	☐ Yes ☐ No Are you Disabled?

Additional Dependent Information *Please check your specific plan design to determine if you are required to choose a PCP.

Relationship (see legend below)	Last Name	First Name	M.I.
Social Security	Birth Date	☐ Male ☐ Female Gender	☐ Yes ☐ No Tobacco Use

Ethnicity**	Email	AvMed PCP/PCP#*	☐ Yes ☐ No Current Patient?	☐ Yes ☐ No Are you Disabled?

Additional Dependent Information *Please check your specific plan design to determine if you are required to choose a PCP.

Relationship (see legend below)	Last Name	First Name	M.I.
Social Security	Birth Date	☐ Male ☐ Female Gender	☐ Yes ☐ No Tobacco Use

Ethnicity**	Email	AvMed PCP/PCP#*	☐ Yes ☐ No Current Patient?	☐ Yes ☐ No Are you Disabled?

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

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, 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. This authorization is valid for twenty-four (24) months from the date of the signature below. I understand that I may revoke this authorization at any time by giving advance written notice to AvMed.

I understand that any dispute with AvMed 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.

AvMed complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-882-8633 (TTY 711). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-882-8633 (TTY 711).

Employee Signature	Date:
Employer/Administrator Signature	Date: