# Employee Status Change Form

AvMed

## Employer & Employee Information

Employer Name _____ Group/Division# _____

If you are enrolled for coverage in an AvMed Engage Plan, you must select a Primary Care Physician (PCP). Please enter the name and ID number of your selected PCP below:

Employee Name _____ AvMed ID# _____ PCP Name _____ PCP ID Number _____

## Employee Information Change (Applies to Subscriber) *check the action that applies*

☐ **Name Change**
Last Name _____ First Name _____ M.I. _____

☐ **Address Change**
Street Address _____ Apt. # _____ City _____ State _____ Zip _____

☐ **Contact Information Change**
Home Phone _____ Cell Phone _____ Work Phone _____ Email _____

## Add Dependent(s) *check the type of event* (Attach separate sheet with event information if additional space is needed, sign and date)

☐ Marriage Event Date: / / ☐ Birth Event Date: / / ☐ Adoption Event Date: / / ☐ Other Event 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 | Tobacco Use? Y / N | Disabled? Y / N |
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**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

## Disenrollment(s) *check the action that applies* (Attach separate sheet with disenrollment information if additional space is needed, sign and date)

☐ **Cancel Entire Coverage** Effective Date: / / Reason for Disenrollment: _____

☐ **Dependent Disenrollment(s)** (List dependent information below)

| Last Name | First Name, M.I. | AvMed ID# | Effective Date | Reason for Disenrollment |
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**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 change my participation under my employer's group plan as indicated above. 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.

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.

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|---|---|
| Employee Signature: | Date: / / |
| Employer/Administrator Signature: | Date: / / |