

Employee Enrollment Form



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 Is your spouse covered by another health carrier? Yes No
 Spouse's Employer: _____ 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: / /

WHITE COPY – AVMED YELLOW COPY – EMPLOYER PINK COPY – EMPLOYEE