

(For Health Plan Use)

GROUP NO.	DIVISION NO.
EFFECTIVE DATE	DENTAL

COMPANY NAME

<b>EMPLOYEE</b>	FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NO.	
	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	HOME ADDRESS			
	CITY	APT. NO.	STATE	ZIP CODE	
	HOME TELEPHONE	BUSINESS TELEPHONE	E-MAIL ADDRESS	DENTAL FACILITY # <i>(If applicable, select One for Self &amp; Family)</i>	
	DATE OF BIRTH Mo Day Yr	OCCUPATION	PRIMARY CARE PHYSICIAN FIRST, LAST NAME <i>(Choose Obstetrician if pregnant)</i>	PROVIDER NO.  / 0	
	CURRENT PATIENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No - If Yes, Is It Due to Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE OF HIRE

**List Only Dependents To Be Covered**

<b>SPOUSE OR DEPENDENT</b>	FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NO.
	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH Mo Day Yr	RELATIONSHIP <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Other	PRIMARY CARE PHYSICIAN FIRST, LAST NAME <i>(Choose Obstetrician if pregnant)</i>
	PROVIDER NO.  / 0	CURRENT PATIENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your Spouse or Dependent currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, provide Employer Name below.	
	EMPLOYER NAME		HEALTH CARRIER	
	Medicare Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, is Coverage due to Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No			

<b>DEPENDENT</b>	FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NO.
	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH Mo Day Yr	RELATIONSHIP <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Other	PRIMARY CARE PHYSICIAN FIRST, LAST NAME <i>(Choose Obstetrician if pregnant)</i>
	PROVIDER NO.  / 0	CURRENT PATIENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>DEPENDENT</b>	FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NO.
	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH Mo Day Yr	RELATIONSHIP <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Other	PRIMARY CARE PHYSICIAN FIRST, LAST NAME <i>(Choose Obstetrician if pregnant)</i>
	PROVIDER NO.  / 0	CURRENT PATIENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		

*(List additional children on a separate application and staple to this application.)*

NOTE: All eligible dependent children age 19 and older must meet the eligibility requirements and provide proof of such status to be eligible for coverage up to the maximum age specified in their Plan Document and Summary Plan Description. If dependents have different last names than that of the main subscriber, ATTACH copies of legal supporting documents evidencing their dependent status. Each member MUST select a primary care physician.

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 punishable as provided in Florida Statutes.

I CERTIFY that the above statements are true and I understand that any material misstatements may be used to contest the validity of benefits.

I UNDERSTAND that any dispute with the Group Health Plan shall be subject to the Plan's Complaint and Grievance Procedure in accordance with the provisions of the Plan Document and Summary Plan Description.

I CERTIFY that I am employed and am eligible, or that I am in a class eligible to participate in my employer's/union's health benefits program.

I CERTIFY that I am familiar with the terms of the Group Health Plan with my Employer, that a copy of said Plan is on file with my employer and that I agree to abide by the terms therein.

I AUTHORIZE any licensed physician, hospital, clinic or other related facility to release for review my or my enrolled family members' medical records to AvMed, provided such records were established while enrolled under this Group Health Plan. This authorization includes psychiatric and substance abuse records as well as concurrent inpatient review.

I hereby apply for membership in the Group Health Plan administered by AvMed and AUTHORIZE my employer/union to deduct from my earnings the necessary contribution, if any, required of me. I understand that my existing group health coverage may be cancelled when this coverage becomes effective.

**To Be Completed By Employer**

DATE OF HIRE	EFFECTIVE DATE
NAME OF DIVISION <i>(If Applicable)</i>	

EMPLOYER SIGNATURE

*(I certify that the above employee is eligible for health benefits).*

DATE \_\_\_\_\_ SUBSCRIBER/EMPLOYEE SIGNATURE \_\_\_\_\_