Small Group Employee Enrollment Form

Coverage Type: ☐ Employee Only ☐ Family

Plan Option: **HMO** ☐ Achieve ☐ Achieve HSAQ* ☐ Engage **POS** ☐ Agility ☐ Agility HSAQ* ☐ Empower *HSA 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:

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:

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

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

Home Phone | Work Phone | Email | Occupation | Marital Status ☐ single ☐ married

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

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

Dependent Information:

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: (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 #	Tobacco Use Y / N	Ethnicity (optional) See Legend Below

Relation to You: **SP** = Spouse, **CH** = Child, **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 me 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.

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

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In today's healthcare environment all stewards entrusted with patient data are required to act in the patient's best interest and provide the highest quality of care possible. As a leader in the healthcare industry AvMed takes this responsibility very seriously. Please complete the following Authorization allowing AvMed and your provider to help you **embrace better health.**

Authorization to Obtain and Release Information:

I hereby authorize AvMed, or AvMed's representatives, to receive and use Protected Health Information (PHI) (e.g., hospital records, physician records, claims or benefit records, pharmacy, or lab results) a) to verify age, gender, geographic area of residence, tobacco use; b) to coordinate medical care and care management, c) and for risk adjustment and/or validation audit purposes required by Health and Human Services (HHS). For this purpose, I authorize AvMed to disclose my PHI to other persons or organizations performing services on AvMed's behalf. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules

My spouse, dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, pharmacy benefit manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., or the Consumer Reporting Agency having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness and copies of any and all individually identifiable health information, including medical records, reports, pharmaceutical records, diagnostic testing, lab work, nonpublic personal health information, and any other non-medical information, to share any and all such information with AvMed, or its legal representatives, to the extent permitted by law.

Term of Authorization

I agree this Authorization will be valid for twenty-four (24) months from the date of the signature below.

Right to Revoke

I understand that I may revoke this authorization at any time by giving advance written notice to AvMed. I am signing this authorization voluntarily and my eligibility for benefits will not be affected if it is not signed. (If this application was completed on a computer, I acknowledge that I have not actually signed this application but instead authorize AvMed to print "Electronic Signature" on this form.)

Employee Signature:	Date: / /
Employer/Administrator Signature:	Date: / /
Dependent(s) Age 18 and Over Signature (if proposed for coverage):	Date: / /
	Date: / /
	Date: / /