Please contact AvMed Medicare if you need information in another language or accessible format (Braille).
OMB No. 0938-1378 Expires:7/31/2023

AvMed

To Enroll in an AvMed Medicare HMO Plan, Please Provide the Following Information: H1016

Please check which plan you want to enroll in:	**Miami-Dade County** ☐ Medicare Choice HMO ☐ Medicare Circle HMO ☐ Access HMO-POS	**Broward County** ☐ Medicare Choice HMO ☐ Medicare Circle HMO ☐ Access HMO-POS ☐ Premium Saver Plan HMO

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: (____/____/_____) M M/D D/Y Y Y Y	Sex: ☐ M ☐ F	Home Phone Number: ( )	Alternate Phone: ( )

Permanent Residence Street Address: (P.O. Box is not allowed)

City:	State:	Zip Code:

Mailing Address: (Only if different from your Permanent Residence Address)
Street Address: City: State: Zip Code:

Email Address (optional):

Please Provide Your Medicare Information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Please choose the name of a Primary Care Physician (PCP):

Name:	Provider Number:

Please choose the name of a dentist:

Name:	Dentist Number:

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to AvMed? ☐ Yes ☐ No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	**Member number for this coverage:**	**Group number for this coverage:**

Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in AvMed.
- By joining this Medicare Advantage Plan, I acknowledge that AvMed will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Please Read and Sign Below (cont.):

- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my coverage begins, I must get all of my medical and prescription drug benefits from AvMed. Benefits and services provided by AvMed and contained in my AvMed "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor AvMed will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1) This person is authorized under State law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare

Signature:	**Today's Date:**

If you're the authorized representative, sign above and fill out these fields:

Name: _____

Address: _____

Phone Number: (____) _____

Relationship to Enrollee: _____

All the fields in the section below are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select if you would prefer us to send you information in a language other than English.
☐ Spanish

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD

Please contact the AvMed Customer Support Center at 1-800-535-9355 (TTY 711) if you need information in an accessible format or language than what is listed above. Our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

Office Use Only:

Name of staff member, agent or broker (if assisted in enrollment): _____

Agent #: _____ Plan ID #: _____ Effective Date of Coverage: _____

Broker Name: _____

ICEP/IEP: _____ AEP: _____ SEP (Type): _____ Not Eligible: _____

Enrollment received by Health Plan:	Deemed Complete:	Enrollment Data Entry:

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.