



Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan.
- I recently moved and this plan is a new option for me
- I have both Medicare and Medicaid or my state helps pay for my Medicare Premiums.
- I receive extra help paying for Medicare prescription drug coverage.
- I am no longer eligible for extra help paying for my Medicare prescription drugs.
- I live in or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility).
- I recently left a PACE program.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
- I am leaving employer or union coverage.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S.
- None of these statements applies to me. *

*Please contact AvMed Health Plan at 1-800-535-9355 (TTY users should call 1-887-442-8633) to see if you are eligible to enroll. We are open Monday through Friday, 9:00 a.m. to 5:30 p.m.

Paying Your Plan Premium

If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail each month, Electronic funds transfer (EFT), or you can also choose to pay your late enrollment penalty premium by automatic deduction from your Social Security check each month.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month.

Please select a payment option:

- Receive a bill each month
- Electronic funds transfer (EFT) from your bank account each month.
- Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions

1. Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to AvMed MA-PD? Yes No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

<u>Name of other coverage</u>	<u>ID # for this coverage</u>	<u>Group # for this coverage</u>
-------------------------------	-------------------------------	----------------------------------

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If "yes" please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street): _____

4. Are you enrolled in your State Medicaid program? Yes No

If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? Yes No

Please check the box below if you would prefer us to send you information in a language other than English:

Spanish

Please contact AvMed Health Plans at 1-800-782-8633 (TTY users should call 1-887-442-8633) if you need information in another format or language than what is listed above. Our office hours are Monday through Friday, 24 hours a day, 7 days a week.



Please Read This Important Information

If you currently have health coverage from an employer or union, joining AvMed Medicare MA-PD Plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining AvMed Medicare MA-PD Plan may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

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

AvMed is a Medicare Advantage plan and has a contract with the Federal government. **I will need to keep my Parts A and B.** I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (*Example: November 15 – December 31 of every year*), or under certain special circumstances.

AvMed Medicare serves a specific service area. If I move out of the area that AvMed Medicare serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of AvMed Medicare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from AvMed Medicare when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date AvMed Medicare coverage begins, I must get all of my health care from AvMed Medicare, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by AvMed Medicare and other services contained in my AvMed Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR AVMED WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with AvMed Health Plans, he/she may be compensated based on my enrollment in AvMed Medicare.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that AvMed will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application.

If signed by an authorized individual (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 AvMed Medicare or by Medicare.

Signature: _____

Today's Date: _____

If you are the authorized representative, you **must sign above** and provide the following information:

Name: _____

Address: _____

Phone Number: _____

Relationship to Enrollee _____

Office Use Only:

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

Plan ID #: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Enrollment received by Health Plan

Deemed Complete

Enrollment Data Entry

Lead Source

Event: _____

Referral Type:

AR PR TM

Advertising: Print DM

TV Radio Website

Broker: _____

EGHP _____

Other: _____