



AVMED MEDICARE ADVANTAGE – H1016

ENROLLMENT APPLICATION INSTRUCTIONS

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 don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare 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 or I recently moved and this plan is a new option for me. I moved on _____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on _____.
- I am moving into, live, or recently moved out of a Long Term Care Facility. (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on _____.
- I recently "left" a PACE program on _____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage that is at least as good as Medicare's). I lost my drug coverage on _____.
- I am leaving employer or union coverage on _____.
- 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. I returned to the U.S. on _____.
- Non of these statement applies to me*

Keep the other copy for yourself as proof of application until you receive your AvMed ID Card. When we receive your completed enrollment form, we will forward the request to Medicare for approval and your effective date.

* Please contact AvMed Medicare Plan Sales Representatives at 1-800-535-9355 (TTY/TDD users should call 1-877-442-8633). Representatives are available to take your calls, Monday through Friday, 9:00 a.m. until 5:30 p.m.

AvMed is a Medicare Advantage organization with a Medicare contract

Please contact AvMed Medicare if you need information in another language or format (Braille)

To Enroll in AvMed Medicare MA-PD Plan, Please Provide the Following Information: H1016

Please check which plan you want to enroll in:

Premier Care Miami-Dade - [\$0 premium/month] Premier Care Broward - [\$0 premium/month]

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

Birth Date: _____ Sex: M F Home Phone Number: _____ Alternate Phone: _____
 (MM/DD/YYYY) () ()

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: _____

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card – OR –
- Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

	
SAMPLE ONLY	
Name: _____	Sex _____
Medicare Claim Number _____	_____
Is Entitled To	Effective Date
HOSPITAL (Part A) _____	_____
MEDICAL (Part B) _____	_____

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

Name: _____ Provider Number: _____

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 benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

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 doesn't cover.

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

Please select a payment option:

- Get 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 don't need regular dialysis any more, or if you had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't 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:

Name of other coverage

ID # for this coverage

Group # for this coverage

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. You could lose your employer or union health coverage if you join AvMed Medicare. 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 isn't any 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 Medicare 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 get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually 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, except for 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 getting assistance from a sales agent, broker, or other individual employed by or contracted with AvMed Health Plans, he/she may be paid 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 AvMed Medicare 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 my behalf of the individual under the laws of the State where I live) 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