

## ENROLLMENT APPLICATION INSTRUCTIONS

**Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year.** There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these period.

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 am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- 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 (insert date)\_\_\_\_\_.
- I recently was released from incarceration. I was released on (insert date)\_\_\_\_\_.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)\_\_\_\_\_.
- I recently obtained lawful presence status in the United States. I got this status on (insert date)\_\_\_\_\_.
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)\_\_\_\_\_.
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date)\_\_\_\_\_.
- I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- I am moving into, live in, 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 (insert date)\_\_\_\_\_.
- I recently "left" a PACE program on (insert date)\_\_\_\_\_.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)\_\_\_\_\_.
- I am leaving employer or union coverage on (insert date)\_\_\_\_\_.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)\_\_\_\_\_.
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date)\_\_\_\_\_.
- I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact the AvMed Customer Support Center at 1-800-535-9355 (TTY 711) to see if you are eligible to enroll. Representatives are available to take your calls, 8:00 a.m. until 8:00 p.m., 7 days a week.

AvMed Medicare is an HMO plan with a Medicare contract and enrollment in AvMed Medicare depends on contract renewal.

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



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

<b>Please check which plan you want to enroll in:</b>		<b>Miami-Dade County</b> <input type="checkbox"/> Medicare Choice HMO <input type="checkbox"/> Medicare Circle HMO	<b>Broward County</b> <input type="checkbox"/> Medicare Choice HMO <input type="checkbox"/> Medicare Circle HMO
LAST Name:	FIRST Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: ( / / ) M M / D D / Y Y Y Y	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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 Insurance Information:**

<p>Please take out your Medicare card to complete this section.</p> <ul style="list-style-type: none"> <li>• Please fill in these blanks so they match your red, white and blue Medicare card</li> <li>– OR –</li> <li>• Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board.</li> </ul>	<p>Name (as it appears on your Medicare card): _____</p> <p>Medicare Number: _____</p> <p>Is Entitled To: _____ Effective Date: _____</p> <p>HOSPITAL (Part A) _____</p> <p>MEDICAL (Part B) _____</p> <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>
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**Please choose the name of a Primary Care Physician (PCP):**

Name:	Provider Number:
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**Please choose the name of a dentist:**

Name:	Dentist Number:
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**Paying Your Plan Premium:**

**If we determine that you owe a late enrollment penalty or if you currently have a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail or electronic funds transfer (EFT) each month. You can also choose to pay your late enrollment penalty premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay AvMed Medicare the Part D-IRMAA.**

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. (cont.)

**Paying Your Plan Premium (cont.):**

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](http://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 or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from:  Social Security  RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

**Please read and answer these important questions:**

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

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain addition information.

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?  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 boxes below if you would prefer us to send you information in a language other than English or in an accessible format:**  Spanish  Accessible formats (Braille, audio tape or large print)

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.

**Please Read This Important Information:**

 **If you currently have health coverage from an employer or union, joining AvMed Medicare HMO 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, 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, he/she may be paid based on my enrollment in AvMed Medicare.

**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 from 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:** \_\_\_\_\_

AvMed complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-882-8633 (TTY 711). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-882-8633 (TTY 711).

**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: