American Care Health Flex Plan

ENROLLMENT APPLICATION

"The benefits provided by this health plan are limited. You should carefully review the benefits offered under this health plan."

Applicant Last Name: First Name: Middle Initial: .

Sex: Date of Birth: / / Social Security Number: - - .

Home Phone: ( ) Work Phone: ( ) County: .

Address : City: State: Zip Code: .

Annual Family Income: Household members: .

Statement of Understanding The Applicant understands that he/she has voluntarily enrolled in American Care Health Flex Plan. The Applicant understands the rules and regulations for acceptance and continued coverage in the plan. The Applicant will be terminated from the plan, with appropriate written notification, if he/she fails to comply with any of the rules and policies of American Care, the State of Florida and the rules governing Health Flex participants.

Per Florida Statute 408.909. Eligibility to enroll in an approved health flex plan is limited to residents of this state who: (1) Are 64 years of age or younger; (2) Have a family income equal to or less than 300 percent of the federal poverty level; (3) Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare or Medicaid, or another public health care program, such as Kidcare, and have not been covered at any time during the past 6 months, except that: a) A person who was covered under an individual health maintenance contract issued by a health maintenance organization licensed under part I of chapter 641 which was also an approved health flex plan on October 1, 2008, may apply for coverage in the same health maintenance organization's health flex plan without a lapse in coverage if all other eligibility requirements are met; or b) A person who was covered under Medicaid or Kidcare and lost eligibility for the Medicaid or Kidcare subsidy due to income restrictions within 90 days prior to applying for health care coverage through an approved health flex plan may apply for coverage in a health flex plan without a lapse in coverage if all other eligibility requirements are met.

BE IT KNOWN, that the undersigned, being of legal age, does hereby depose and say under oath as follows: I am applying to a Health Flex Plan as defined by Florida law. I certify that I meet the eligibility requirement criteria as outlined in this form. I understand that this information will be furnished to the State of Florida Agency for Health Care Administration and to the Office of Insurance Regulation for verification of compliance with Health Flex plans rules and regulations. I understand that providing false information to the State of Florida is a criminal offense. I affirm that the foregoing is true except as to statements made upon information and belief, and as to those I believe them to be true.

Witness my hand under the penalties of perjury this _____ day of _____, 20____.

_____
Applicant's Signature

STATE OF FLORIDA, COUNTY OF _____

Personally appeared before me the above named, personally known to me (or proved to me on the basis of satisfactory evidence), who, being duly sworn, deposes and says that he executed the above instrument and that the statements and answers contained therein are true and correct to the best of his or her knowledge and belief.

Subscribed and sworn to before me this _____ day of _____, 20_____

(Notary Public): Affiant: ( ) Known, ( ) Unknown, ID Produced

(SEAL)

Primary Care Provider Requested: _____ Agent ID: _____