Enrollment / Change Form
26 - 50 Eligible Employees

COVENTRY Health Care
Coventry Health and Life Insurance Company

* Denotes required fields for enrollment. For items with ** please select a Reason for Enrollment **OR** a Reason for Change.

A EMPLOYER INFORMATION: To Be Completed By Employer

☐ New Group ☐ New Enrollment ☐ Change ☐ Waive (please complete section F)

Company Name:

*Group No.:

Date Employed Full Time:

*Effective Date of Coverage or Change

**Reason for Enrollment

☐ New Group: ☐ New Hire:
☐ COBRA: ☐ Retired:
☐ Open Enrollment: ☐ Qualifying Event (Reason):

Date

**Reason for Change:

(Please check all that apply and include supporting documentation.)

☐ Enroll Dependent ☐ Terminate Dependent
☐ Terminate Subscriber ☐ Name Change (Previous Name)
☐ Address/Phone

Termination Reason:

☐ Group Request ☐ Member Request ☐ Deceased

Employee Status:

☐ Active ☐ COBRA ☐ Salary ☐ Hourly Number of hours a week ☐ Retired ☐ Other

Benefits Administrator Approval:

Date:

B SUBSCRIBER INFORMATION

Type of Coverage: ☐ Employee ☐ Employee/Spouse ☐ Employee/Children ☐ Employee/Spouse/Children

*Last Name *First Name MI

*Gender ☐ Male ☐ Female

*Birthdate

*Social Security Number

*Address

*City *State *Zip Code

Email Address

Height Weight

Marital Status (please check one.)

☐ Single/Widowed ☐ Married ☐ Divorced ☐ Separated

Work Phone Home Phone

C FAMILY MEMBERS TO BE COVERED OR DELETED

If address and phone numbers of covered dependents are different from that of policy holder, please attach that information on a separate sheet of paper.

☐ Add ☐ Delete

*Last Name *First Name MI

*Gender: ☐ Male ☐ Female

Birthdate Height Weight Student/Disabled

☐ Student ☐ Disabled

Relationship ☐ Spouse ☐ Child

Dependent Different Address

Social Security Number

☐ Add ☐ Delete

*Last Name *First Name MI

*Gender: ☐ Male ☐ Female

Birthdate Height Weight Student/Disabled

☐ Student ☐ Disabled

Relationship ☐ Spouse ☐ Child

Dependent Different Address

Social Security Number

Applicant Name: ______________________________

☐ Add ☐ Delete	*Last Name		*First Name			MI
*Gender: ☐ Male ☐ Female	Birthdate	Height	Weight	Student/Disabled ☐ Student	☐ Disabled	
	Relationship ☐ Spouse ☐ Child	Dependent Different Address		Social Security Number		
☐ Add ☐ Delete	*Last Name		*First Name			MI
*Gender: ☐ Male ☐ Female	Birthdate	Height	Weight	Student/Disabled ☐ Student	☐ Disabled	
	Relationship ☐ Spouse ☐ Child	Dependent Different Address		Social Security Number		
☐ Add ☐ Delete	*Last Name		*First Name			MI
*Gender: ☐ Male ☐ Female	Birthdate	Height	Weight	Student/Disabled ☐ Student	☐ Disabled	
	Relationship ☐ Spouse ☐ Child	Dependent Different Address		Social Security Number		

D OTHER MEDICAL AND/OR PHARMACY COVERAGE INFORMATION

When coverage begins, will you or any of your family members have any other medical insurance coverage? **Yes** ☐ **No** ☐

If you answered yes, please complete Section D.

If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)

Other Insurance Company Name	Policy Holder Name	Covered Dependents

If Prior Medical Coverage Has Been Entered It Will Appear on the Following Page(s)

Medicare Information

If Medicare Information Has Been Entered It Will Appear on the Following Page(s)

Employee Name: ___________________________ SSN: ________________________________

C FAMILY MEMBERS TO BE COVERED OR DELETED

If address and phone numbers of covered dependents are different from that of policy holder, please attach that information on a separate sheet of paper.

☐Add
☐Delete

*Last Name ______________________ *First Name ______________________ MI ____

*Gender
☐ Male
☐ Female

*Relationship
☐ Spouse
☐ Child
☐ Other ______________

Student/ Disabled
☐Student
☐ Disabled

*Birthdate ______________

Height ________ Weight ________

Social Security Number ______________

Dependent Different Address

☐Add
☐Delete

*Last Name ______________________ *First Name ______________________ MI ____

*Gender
☐ Male
☐ Female

*Relationship
☐ Spouse
☐ Child
☐ Other ______________

Student/ Disabled
☐Student
☐ Disabled

*Birthdate ______________

Height ________ Weight ________

Social Security Number ______________

Dependent Different Address

☐Add
☐Delete

*Last Name ______________________ *First Name ______________________ MI ____

*Gender
☐ Male
☐ Female

*Relationship
☐ Spouse
☐ Child
☐ Other ______________

Student/ Disabled
☐Student
☐ Disabled

*Birthdate ______________

Height ________ Weight ________

Social Security Number ______________

Dependent Different Address

☐Add
☐Delete

*Last Name ______________________ *First Name ______________________ MI ____

*Gender
☐ Male
☐ Female

*Relationship
☐ Spouse
☐ Child
☐ Other ______________

Student/ Disabled
☐Student
☐ Disabled

*Birthdate ______________

Height ________ Weight ________

Social Security Number ______________

Dependent Different Address

Employee Name: ______________________ SSN: ______________________

☐ Add
☐ Delete

*Last Name ______________________ *First Name ______________________ MI ____

*Gender: ☐ Male ☐ Female

*Relationship: ☐ Spouse ☐ Child ☐ Other ______________

Student/ Disabled: ☐ Student ☐ Disabled

*Birthdate ______________

Height ________ Weight ________

Social Security Number ______________

Dependent Different Address

☐ Add
☐ Delete

*Last Name ______________________ *First Name ______________________ MI ____

*Gender: ☐ Male ☐ Female

*Relationship: ☐ Spouse ☐ Child ☐ Other ______________

Student/ Disabled: ☐ Student ☐ Disabled

*Birthdate ______________

Height ________ Weight ________

Social Security Number ______________

Dependent Different Address

☐ Add
☐ Delete

*Last Name ______________________ *First Name ______________________ MI ____

*Gender: ☐ Male ☐ Female

*Relationship: ☐ Spouse ☐ Child ☐ Other ______________

Student/ Disabled: ☐ Student ☐ Disabled

*Birthdate ______________

Height ________ Weight ________

Social Security Number ______________

Dependent Different Address

☐ Add
☐ Delete

*Last Name ______________________ *First Name ______________________ MI ____

*Gender: ☐ Male ☐ Female

*Relationship: ☐ Spouse ☐ Child ☐ Other ______________

Student/ Disabled: ☐ Student ☐ Disabled

*Birthdate ______________

Height ________ Weight ________

Social Security Number ______________

Dependent Different Address

Employee Name: ______________________ SSN: ______________________

☐Add
☐Delete

*Last Name ______ *First Name ______ MI ___

*Gender
☐ Male
☐ Female

*Relationship
☐ Spouse
☐ Child
☐ Other ______

Student/ Disabled
☐Student
☐ Disabled

*Birthdate ______

Height ______ Weight ______

Social Security Number ______

Dependent Different Address

☐Add
☐Delete

*Last Name ______ *First Name ______ MI ___

*Gender
☐ Male
☐ Female

*Relationship
☐ Spouse
☐ Child
☐ Other ______

Student/ Disabled
☐Student
☐ Disabled

*Birthdate ______

Height ______ Weight ______

Social Security Number ______

Dependent Different Address

☐Add
☐Delete

*Last Name ______ *First Name ______ MI ___

*Gender
☐ Male
☐ Female

*Relationship
☐ Spouse
☐ Child
☐ Other ______

Student/ Disabled
☐Student
☐ Disabled

*Birthdate ______

Height ______ Weight ______

Social Security Number ______

Dependent Different Address

☐Add
☐Delete

*Last Name ______ *First Name ______ MI ___

*Gender
☐ Male
☐ Female

*Relationship
☐ Spouse
☐ Child
☐ Other ______

Student/ Disabled
☐Student
☐ Disabled

*Birthdate ______

Height ______ Weight ______

Social Security Number ______

Dependent Different Address

Employee Name: ____________________ SSN: ____________________

☐ Add
☐ Delete

*Last Name ____________ *First Name ____________ MI ____

*Gender
☐ Male
☐ Female

*Relationship
☐ Spouse
☐ Child
☐ Other ____________

Student/ Disabled
☐ Student
☐ Disabled

*Birthdate ____________

Height ______ Weight ______

Social Security Number ____________

Dependent Different Address

☐ Add
☐ Delete

*Last Name ____________ *First Name ____________ MI ____

*Gender
☐ Male
☐ Female

*Relationship
☐ Spouse
☐ Child
☐ Other ____________

Student/ Disabled
☐ Student
☐ Disabled

*Birthdate ____________

Height ______ Weight ______

Social Security Number ____________

Dependent Different Address

☐ Add
☐ Delete

*Last Name ____________ *First Name ____________ MI ____

*Gender
☐ Male
☐ Female

*Relationship
☐ Spouse
☐ Child
☐ Other ____________

Student/ Disabled
☐ Student
☐ Disabled

*Birthdate ____________

Height ______ Weight ______

Social Security Number ____________

Dependent Different Address

☐ Add
☐ Delete

*Last Name ____________ *First Name ____________ MI ____

*Gender
☐ Male
☐ Female

*Relationship
☐ Spouse
☐ Child
☐ Other ____________

Student/ Disabled
☐ Student
☐ Disabled

*Birthdate ____________

Height ______ Weight ______

Social Security Number ____________

Dependent Different Address

Applicant Name: _____

E HEALTH INFORMATION

(Please answer each question fully and accurately. Incomplete answers could delay the processing of your requested coverage.)
Please provide the health history of any medical conditions positively diagnosed or treated for you and your family members who will be covered on this application. Please CIRCLE all applicable conditions and provide details for all "YES" answers in the appropriate section. Conditions include but are not limited to the following:

1) AIDS, HIV, Alcohol or Drug Abuse, Arthritis, Birth defects, Cancer, Diabetes, Disorder of the neck/back/spine, Heart conditions, Intestinal, Liver (Cirrhosis, Hepatitis B, C, or D), Lung conditions, Organ transplant, Stroke, or Vascular (blood vessel) disorders (Circle all that apply and give details below)

☐ Yes ☐ No

2) Any surgery or medical treatment discussed, planned, or recommended (Please give full details below)

☐ Yes ☐ No

3) Is anyone currently pregnant
If YES, Due Date: _____

☐ Yes ☐ No

4) Are there any other medical conditions not listed above (Please give full details below)

☐ Yes ☐ No

5) Anyone currently taking any prescription medication (Please give full details below)

☐ Yes ☐ No

If you need additional space please attach another sheet with your signature and date on it as verification that the information is yours.

Question Number	Person's Name	Condition	Treatment (Month/Year)	Medications (oral, injectable, infusion, or inhaled)	Is further treatment needed? If yes, please explain:

If Medical Information Has Been Entered It Will Appear on the Following Page(s)

F **WAIVER** **My employer has given me an opportunity to apply for group health coverage for myself and my dependents (if applicable)**

I understand that if I decide to apply for health coverage for myself and any applicable dependents at a later date, neither my dependents nor I will be eligible for coverage until (1) my employer's next open enrollment period, or (2) there is a qualifying event as defined in the Group policy.

If Waiving Coverage, Information Will Appear on the Following Page(s)

Employee Signature (only if you are waiving coverage) Date:

G **AGREEMENT AND AUTHORIZATION** **Please read the following carefully.**

1. I apply for membership in Coventry Health and Life Insurance Company, (CHL) for myself and for any eligible dependents listed. I authorize my employer to make deductions, if any, toward the premium cost of CHL.
2. I and my eligible dependents shall abide by the provisions of coverage in the Group Enrollment Agreement, Certificate of Coverage and Benefit Riders under which we are enrolled.
3. By signing this form, I authorize my employer & any physician, hospital, medical group or other facility providing me care, treatment or consultation, to disclose to CHL, or receive from CHL, any medical or claim information pertaining to the persons identified in this enrollment form receiving coverage under this plan, as may be necessary to enable CHL to make coverage determinations, pay claims or otherwise administer plan programs, including without limitation, credentialing of physicians and as applicable, other providers all of which shall be conducted in accordance with state and federal confidentiality laws. CHL will not disclose any information pertaining to HIV/AIDS or chemical dependency/substance abuse except as specifically permitted by applicable law.
4. I understand and agree no benefits shall take effect until this application is approved by CHL.
5. I understand that my membership may be cancelled for one or both of the following reasons: (1) failure to pay the amount due under the Group Enrollment Agreement or Certificate of Coverage, for which I am legally responsible, or (2) fraud or material misrepresentation in enrollment or in the use of services of facilities.
6. I understand that it is my responsibility to report to CHL any change in the eligibility of myself or my dependents.

By signing this form I certify ALL information is true and accurate.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

I HAVE READ AND AGREE TO THE STATEMENTS ABOVE. (Signature Required Below)

Applicant Signature **Date**

Applicant Printed Name

GENERAL PROVISIONS

1. ENROLLMENT RIGHTS NOTICE (Waived Coverage) - I understand that if I and/or any of my dependents, if any, waive coverage at this time and desire to participate in the plan at a future date, coverage could be subject to treatment as a late enrollee at that time. I further understand that even if I decline enrollment for myself or my dependents, spouse included, because of other health coverage at this time, I will still have the right to enroll myself and/or my dependents in this plan, provided I request enrollment within thirty-one (31) days of the time that such coverage ends. I also understand that if a new dependent relationship is formed due to marriage, birth, adoption, placement for adoption, or court order, I may be able to enroll myself and/or my dependents provided I request enrollment within thirty-one (31) days of such marriage, ninety (90) days of such birth or sixty (60) days of such adoption, placement for adoption or court order.

2. RESOLUTION OF DISPUTES - Please refer to the Certificate of Coverage, which outlines in detail CHL's Member Grievance and Appeals Procedure.

Products are underwritten by Coventry Health & Life Insurance Company.

AR DOI Approved 02/11/08