COVENTRY Health Care
Coventry Health and Life Insurance Company

Enrollment, Health Statement and Declination Form

3030 NW Expressway, Suite #625; Oklahoma City, OK 73112
PH: 1-866-219-7695 - Fax: 1-606-878-4585

DO NOT WRITE IN MARGINS
Office Use Only
Group No.: _____

A. Employee Information

Last Name	First Name	MI	Home Phone	☐ FMLA ☐ COBRA ☐ State Continuation
Address	City	State / Zip	County	Effective date of FMLA, COBRA or Continuation coverage:
Group/Employer Name	Occupation	**Hire Date**	Work Phone / Email address	

Effective Date of Coverage: _____ Plan: ☐ PPO ☐ QHDHP Selection (Optional): ☐ Base ☐ Buy-up ☐ Buy-down ☐ Other:

B. Declination of Coverage (If declining coverage, please complete this section, skip sections C and D, then sign and date the back of this form.)

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

If you are waiving/declining medical coverage for yourself or your dependents (including your spouse) because of other medical coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within 31 days after your other coverage ends, or within 60 days after losing eligibility for any CHIP or Medicaid subsidy or becoming eligible for any CHIP or Medicaid subsidy. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after a marriage, birth, adoption or placement for adoption or within 60 days after losing eligibility for any CHIP or Medicaid subsidy or becoming eligible for any CHIP or Medicaid subsidy. If you are waiving medical coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period.

C. Coverage Selection and Member Information

☐ Employee Only ☐ EE + Spouse ☐ EE + Child(ren) ☐ EE + Family Is the Employee on a Leave of Absence? ☐ FMLA ☐ Worker's Compensation ☐ Disability or ☐ Retired

Last Name, First Name, MI	Gender	Birth date	Height	Weight	Social Security Number	Status	Relationship to Employee	Dependent Address (if different than Employee Address)
Employee	☐ M ☐ F					☐ Active ☐ On Leave ☐ Retired	N/A	N/A
Spouse	☐ M ☐ F					☐ Common Law Married* ☐ Disabled		
Child	☐ M ☐ F					☐ Lives with Employee ☐ Disabled		
Child	☐ M ☐ F					☐ Lives with Employee ☐ Disabled		
Child	☐ M ☐ F					☐ Lives with Employee ☐ Disabled		
Child	☐ M ☐ F					☐ Lives with Employee ☐ Disabled		

Other Medical Insurance Coverage? ☐ Yes ☐ No

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

* Coverage will not be offered to dependents living outside of the service area unless the Dependent Child is a qualified Full-Time Student, or when Dependent Child coverage is required by a court decree (please provide court decree). You must submit affidavit with Enrollment if indicating marriage under Common Law.

Name: ______________________________ SSN: ____________________________________

Last Name, First Name, MI	Gender		Birth date	Height	Weight	Social Security Number	Status	Relationship to Employee	Dependent Address (If different than Employee Address)
	☐ M	☐ F					☐ Lives with Employee ☐ Disabled		
	☐ M	☐ F					☐ Lives with Employee ☐ Disabled		
	☐ M	☐ F					☐ Lives with Employee ☐ Disabled		
	☐ M	☐ F					☐ Lives with Employee ☐ Disabled		
	☐ M	☐ F					☐ Lives with Employee ☐ Disabled		
	☐ M	☐ F					☐ Lives with Employee ☐ Disabled		
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	☐ M	☐ F					☐ Lives with Employee ☐ Disabled		
	☐ M	☐ F					☐ Lives with Employee ☐ Disabled		
	☐ M	☐ F					☐ Lives with Employee ☐ Disabled		
	☐ M	☐ F					☐ Lives with Employee ☐ Disabled		

D. Health Information – used for rating purposes only.

Please answer each question fully and accurately for yourself and your dependent(s) unless you are waiving all coverage. You must give full details for all "Yes" questions in space provided below. If necessary, please date and sign any additional pages. Incomplete answers could delay the decision on your request for coverage. You should not include any of your and/or your dependent's family history or genetic information (including, but not limited to, genetic testing, genetic service, genetic counseling, or genetic diseases for which you and/or your dependents may be at risk).

1.	Is anyone currently taking medication or receiving any medical treatment of any kind? List below.	☐ Y ☐ N	4.	Has anyone smoked cigarettes or used tobacco products within the past 12 months?	☐ Y ☐ N
2.	Within the past 5 years, have you or your dependents been advised to have surgery, treatment or tests **NOT YET** performed?	☐ Y ☐ N	5.	Are you or any family member pregnant? (Indicate expected delivery date and any complications.) Due date:	☐ Y ☐ N
3.	Has anyone been to the emergency room or hospitalized within the past 5 years?	☐ Y ☐ N	6.	Has anyone had an organ transplant, in treatment, or on a waiting list for an organ transplant?	☐ Y ☐ N

Has anyone within the past 10 years, had any diagnosis or treatment for any of the following:

7.	Chest pain or pressure, heart trouble, heart attack, heart murmur, rapid, slow or irregular heart beat?	☐ Y ☐ N	16.	Mental or nervous disorders (including emotional or behavioral disorders)?	☐ Y ☐ N
8.	High blood pressure, stroke or other circulatory problems?	☐ Y ☐ N	17.	Cancer, tumors, cysts, polyps or growths of any kind?	☐ Y ☐ N
9.	Epilepsy, seizures, convulsions or frequent headaches?	☐ Y ☐ N	18.	Rashes or any other skin condition?	☐ Y ☐ N
10.	Pancreas, liver, spleen or gallbladder problems?	☐ Y ☐ N	19.	Disease or disorder of the eyes, ears, nose, mouth, throat, or sinuses?	☐ Y ☐ N
11.	Prostate, kidney or bladder problems, or blood in the urine?	☐ Y ☐ N	20.	Back, neck or spinal problems; bone, jaw or muscle condition?	☐ Y ☐ N
12.	Any male or female reproductive organs, menstruation problems, abnormal pap test?	☐ Y ☐ N	21.	Arthritis, gout or joint disorder?	☐ Y ☐ N
13.	Venereal disease (such as gonorrhea, syphilis, genital herpes, chlamydia) or other infectious disease?	☐ Y ☐ N	22.	Blood disorders; diabetes, or disease or disorder of the thyroid, breast or other glands?	☐ Y ☐ N
14.	Bronchitis, tuberculosis, asthma, emphysema, pneumonia, or other respiratory or lung problems?	☐ Y ☐ N	23.	Alcohol or drug problem, dependency, abuse, overdose or drug reaction?	☐ Y ☐ N
15.	Crohn's disease, ulcers, colitis, intestinal disorders, hemorrhoids, proctitis, hernia, other digestive problems?	☐ Y ☐ N	24.	Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the HIV virus?	☐ Y ☐ N

Please give full details for all "Yes" questions (above). If necessary, attach additional pages. Please date and sign any additional pages.

Question #	Covered Person's Name	Diagnosis and Dates of Treatment	Medications	Doctor's Name

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

Agreement and Authorization

Unless waiving coverage as listed in Section B, by signing this form, I am applying for covered services for which my family and I are eligible and I authorize my employer to deduct from my earnings any required contributions. I agree on behalf of myself and those family members enrolled ("Dependents"), for whom I have the authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as my "Enrolled Family"), that Preferred Health Systems Insurance Company, Preferred Plus of Kansas, Inc., Coventry Health Care of Kansas, Inc. and Coventry Health and Life Insurance Company, and/or their authorized representatives (collectively referred to as "Health Plan") may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering my health insurance benefit, including for treatment, payment or health care operations, as those terms are explained in detail in Health Plan's Notice of Privacy Practices and to the extent permitted by law.

I also agree on behalf of myself and my Dependents, that, to the extent permitted by law, health care providers, insurers, claims administrators, employers and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, autoimmune deficiency syndrome, AIDS related complex, human immunodeficiency virus or genetic conditions to Health Plan for Health Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law.

I represent that my answers to the questions on this form are complete and accurate to the best of my knowledge, and I understand that my answers, except for those questions in Section D, will be used to determine eligibility for coverage. If I have, on behalf of myself and my Dependents, performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact, it could provide the basis to reform, refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force. After coverage has been in force for two years, no statement except fraudulent statements I make voids my coverage or reduces my benefits.

Plans offered by Preferred Health Systems Insurance Company are underwritten by Preferred Health System Insurance Company. Plans offered by Preferred Plus of Kansas, Inc., are underwritten by Preferred Plus of Kansas, Inc. Plan offered by Coventry Health Care of Kansas, Inc. are underwritten by Coventry Health Care of Kansas, Inc. Plans offered by Coventry Health and Life Insurance Company are underwritten by Coventry Health and Life Insurance Company.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

I have read and agree to the statements above.

Employee Signature	Employee Printed Name	Date

INCOMPLETE FORMS WILL BE RETURNED, DELAYING ELIGIBILITY, CLAIMS PROCESSING, RECEIPT OF ID CARDS(S) AND MAY RESULT IN DENIED CLAIMS