COVENTRY Health Care of the Carolinas, Inc.

Enrollment/Change Form

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**

Company Name:	*Group No.:
*Date Employed Full Time:	*Effective Date of Coverage or Change

**REASON FOR ENROLLMENT		**REASON FOR CHANGE: (Please check all that apply and include supporting documentation.)	
☐ New Group	☐ New Hire	☐ Enroll Dependent	☐ Terminate Dependent
☐ COBRA	☐ Retired	☐ Terminate Subscriber	☐ Name Change (Previous Name)
☐ Open Enrollment	☐ Qualifying Event (Reason)	☐ Address/Phone	____________________________
	Date:	**Termination Reason**:	
		☐ Group Request ☐ Member Request ☐ Deceased	

EMPLOYEE STATUS:

☐ Active ☐ COBRA ☐ Salary ☐ Hourly/Numbers of hours a week ____ ☐ Other ________________________

B SUBSCRIBER INFORMATION

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS: ☐ **None/Waive (please complete Section E and F)**

☐ Coventry Health Care of the Carolinas, Inc. POS ___ ☐ Coventry Health and Life Insurance PPO ___

☐ Coventry Health Care of the Carolinas, Inc. HMO ___ ☐ Other __________________

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		

Marital Status (please check one.) ☐ Single/Widowed ☐ Married ☐ Divorced ☐ Separated

Work Phone	Home Phone
♦Tobacco Use In Last 6 Months? ☐ Yes ☐ No	Primary Care Provider PCP#: PCP Name:

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	*Relationship	Disabled	*Birthdate	*Social Security Number
☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Other __________________	☐ Disabled	Tobacco Use In Last 6 Months? ☐ Yes ☐ No	Primary Care Provider PCP#: PCP Name:

♦ Tobacco includes cigarettes, pipe, cigars, snuff, or chewing tobacco used on average four times per week during the past six months. Religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives) are exempt. Tobacco rates will not apply to applicants under the age of 18.

*Applicant Name: ______________________________________ (required)

☐ Add ☐ Delete	*Last Name	*First Name	MI

*Gender	*Relationship	Disabled	*Birthdate	*Social Security Number
☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Other ______________	☐ Disabled	Tobacco Use In Last 6 Months? ☐ Yes ☐ No	Primary Care Provider PCP#: PCP Name:

☐ Add ☐ Delete	*Last Name	*First Name	MI

*Gender	*Relationship	Disabled	*Birthdate	*Social Security Number
☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Other ______________	☐ Disabled	Tobacco Use In Last 6 Months? ☐ Yes ☐ No	Primary Care Provider PCP#: PCP Name:

☐ Add ☐ Delete	*Last Name	*First Name	MI

*Gender	*Relationship	Disabled	*Birthdate	*Social Security Number
☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Other ______________	☐ Disabled	Tobacco Use In Last 6 Months? ☐ Yes ☐ No	Primary Care Provider PCP#: PCP Name:

D OTHER MEDICAL AND/OR PHARMACY COVERAGE INFORMATION

When coverage with Coventry Health Care of the Carolinas, Inc. begins, will you or any of your family members have any other medical insurance coverage? If you answered yes, please complete below. ☐ Yes ☐ No

COVERAGE TYPE: ☐ Group Policy ☐ Individual Policy ☐ Medicare ☐ Pharmacy ☐ Medicaid ☐ Tricare ☐ Other ______________

Other Insurance Company Name	Policy Holder Name	Covered Dependents

Relationship	Gender	Birthdate	Effective Date of Other Insurance
☐ Spouse ☐ Child ☐ Other ____________	☐ Male ☐ Female		

Other Insurance Company Name	Policy Holder Name	Covered Dependents

Relationship	Gender	Birthdate	Effective Date of Other Insurance
☐ Spouse ☐ Child ☐ Other ____________	☐ Male ☐ Female		

Medicare Information

			Reason for Medicare Eligibility
☐ **Subscriber or** ☐ **Dependent**	Dependent's Last Name		☐ Over 65 ☐ Disabled ☐ End Stage Renal Disease (ESRD) ☐ Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's Disease)
Effective Date Of: Part A	Dependent's First Name	MI	
Part B	Medicare #		
Part D			

*Applicant Name: ______________________________________ (required)

☐ **Subscriber or** ☐ **Dependent**	Dependent's Last Name		**Reason for Medicare Eligibility**
Effective Date Of: Part A	Dependent's First Name	MI	☐ Over 65 ☐ Disabled ☐ End Stage Renal Disease (ESRD) ☐ Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's Disease)
Part B	Medicare #		
Part D			

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

I have declined to apply for coverage for ☐ myself, ☐ spouse, ☐ dependents

Reason for decline: ☐ Other health insurance ☐ Spousal coverage ☐ Other reason (please explain)

____

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 EOC/COI.

____ ______________________

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

F CONDITIONS OF ENROLLMENT Please read the following carefully.

I hereby apply for membership or request a change in membership in this Coventry Health Care of the Carolinas, Inc./Coventry Health and Life Insurance Company (CHC Carolinas/CHL) Plan. I understand that my enrollment and benefits are in accordance with those described in the applicable Evidence/Certificate of Coverage or Certificate of Insurance, and Group Contract or Group Policy. I authorize 1) all health providers and insurers to furnish CHC Carolinas/CHL, and 2) all health providers and CHC Carolinas/CHL to furnish all insurers and health providers records concerning me or any member of my family for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative is entitled to receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that all the above information is correct. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through CHC Carolinas/CHL. For purposes of collecting information for an insurance policy application,policy reinstatement, or a request for change in policy benefits, this authorization shall remain valid for thirty months from the date the authorization is signed. It is further understood that CHC Carolinas/CHL reserves the right to re-rate coverage if any supplied information is materially inaccurate or incomplete, or rescind coverage in the event of fraud or intentional material misrepresentation.

AGREEMENT AND AUTHORIZATION

By signing this form, I agree on behalf of myself and those family members enrolled in this CHC Carolinas/CHL Plan (Dependents) for whom I have authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as Enrolled Family) that CHC Carolinas/CHL 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 treatment, payment, or health care operations, as those terms are explained in detail in CHC Carolinas/CHL's Notice of Privacy Practices and to the extent permitted by law. My Enrolled Family's consent includes agreement for the use or disclosure of health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV). By signing this form, 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, AIDS, ARC, or HIV to CHC Carolinas/CHL for CHC Carolinas/CHL's administration of health insurance benefits including treatment, payment, or health care operations purposes and other purposes permitted by law.

I HAVE READ AND AGREE TO THE STATEMENTS ABOVE. (SIGNATURE REQUIRED BELOW)

____ ______________________

Applicant Signature **Date**

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Applicant Printed Name