COVENTRY
Health Care of Virginia, Inc.

Enrollment/Change Form

COVENTRY
Health and Life Insurance Company

HMO and POS products are underwritten by Coventry Health Care of Virginia, Inc. (CHCVA). PPO products are underwritten by Coventry Health and Life Insurance Company (CHLIC).

A EMPLOYER INFORMATION: To Be Completed By Employer

EMPLOYEE STATUS:

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

Group Name:	Group No.:
Benefit Administrator Signature and Date:	Effective Date:

REASON FOR ENROLLMENT

☐ New Group	☐ New Hire Date: _____	☐ Open Enrollment	☐ Retired Date: _____
☐ COBRA Date Eligible: _____		☐ Continuation Date Eligible: _____	
☐ Qualifying Event Description: _____		Date: _____	

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

☐ Add Dependent	☐ Term Subscriber	☐ New Group	☐ Address, Phone, or Email Change
☐ Name Change (Previous: _____)			

TERMINATION

☐ Terminated (Reason): _____ Date: _____	☐ Laid Off/Date: _____
☐ Retired/Date Retired: _____	☐ Deceased/Date of Death: _____

B SUBSCRIBER INFORMATION

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

☐ CHCVA HMO _____ ☐ CHCVA POS _____ ☐ CHLIC PPO _____

Type of Coverage: ☐ Employee ☐ Employee/Spouse ☐ Employee/Child ☐ Employee/Children ☐ Employee/Family ☐ Employee/Partner

Last Name	**First Name**	**MI**

Gender ☐ Male ☐ Female	**Birthdate**	**Social Security Number**

Street Address

City	**State**	**ZIP Code**

Email Address	**Work/Day Phone**	**Home Phone**

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

♦Tobacco Use In Last 6 Months? ☐ Yes ☐ No	**Primary Care Provider** PCP #:	**Current Patient?** ☐ Yes ☐ No

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 _____	**Disabled** ☐ Disabled	**Birthdate**	**Social Security Number**

Tobacco Use In Last 6 Months? ☐ Yes ☐ No	**Primary Care Provider** PCP #:	**Current Patient?** ☐ Yes ☐ No

♦ 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.

*Applicant Name: ____ (required)

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

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

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

D OTHER INSURANCE

When coverage with CHCVA/CHLIC 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 ☐ Spouse ☐ Child ☐ Other ______________	**Gender** ☐ Male ☐ Female	**Birthdate**	Effective Date of Other Insurance
Other Insurance Company Name	Policy Holder Name		Covered Dependents
Relationship ☐ Spouse ☐ Child ☐ Other ______________	**Gender** ☐ Male ☐ Female	**Birthdate**	Effective Date of Other Insurance
Other Insurance Company Name	Policy Holder Name		Covered Dependents
Relationship ☐ Spouse ☐ Child ☐ Other ______________	**Gender** ☐ Male ☐ Female	**Birthdate**	Effective Date of Other Insurance

Medicare Information

☐ **Subscriber or** ☐ **Dependent**	Dependent's Last Name		**Reason for Medicare Eligibility**
<u>**Effective Date Of:**</u> Part A	Dependent's First Name	MI	☐ Over 65 ☐ Disabled ☐ Kidney Disease (ESRD) ☐ ALS (Lou Gehrig's Disease)
Part B	Medicare #		
Part D			

*Applicant Name: _____ (required)

☐ **Subscriber or** ☐ **Dependent**	Dependent's Last Name		**Reason for Medicare Eligibility**
			☐ Over 65
Effective Date Of:	Dependent's First Name	MI	☐ Disabled
Part A			☐ Kidney Disease (ESRD)
Part B	Medicare #		☐ ALS (Lou Gehrig's Disease)
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 AGREEMENT AND AUTHORIZATION — Please read the following carefully.

I hereby apply for membership or request a change in membership in this Coventry Health Care of Virginia, Inc. (CHCVA)/Coventry Health and Life Insurance Company (CHLIC) Plan. I understand that my enrollment and benefits are in accordance with those described in the applicable Evidence of Coverage or Certificate of Insurance, and Group Agreement/Policy. I authorize 1) all health providers and insurers to furnish CHCVA/CHLIC and 2) all health providers and 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 for health benefits through CHCVA/CHLIC. 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 (30) months from the date the authorization is signed. For purposes of collecting information in connection with a claim for benefits under this CHCVA/CHLIC Plan this authorization is valid for the duration of your coverage under the Plan.

I certify on behalf of myself and any applicable dependents that to the best of my knowledge and belief all information submitted to CHCVA/CHLIC is complete and true, and I agree that this information shall be taken as the basis of the issuance of coverage for me and for each of the eligible dependents listed. I understand that CHCVA/CHLIC reserves the right to rescind coverage if any supplied information is materially inaccurate or incomplete. All claims related to such fraud or misrepresentation and charges incurred after the termination will become my liability.

I understand and agree that CHCVA/CHLIC will rely upon the information and answers I have provided as the basis for establishing group premium rates applicable to such policy. I understand that I may be contacted by CHCVA/CHLIC to obtain additional follow-up information on myself and/or my dependents.

If enrolling in an HMO plan, I acknowledge an out-of-network plan has been offered.

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

_____ _____

Applicant Signature **Date**

_____

Applicant Printed Name