

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: ____/____/____

****Reason for Enrollment:**

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

**** Reason for Change:**
(Please check all that apply and include supporting documentation.)

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

Pre-existing conditions exclusion period is 12 months for timely enrollees and 18 months for late enrollees unless you provide proof of coverage from your prior plan(s).

Termination Reason:

Group Request Member Request Deceased

EMPLOYEE STATUS:

Active COBRA / State Continuation Other _____

Salary Hourly Number of hours per week: ____

Benefits Administrator Approval: _____ Date: _____

B SUBSCRIBER INFORMATION

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS:

POS HMO HDHP PPO Out-of-Network Other _____

None / Waive (Please complete section E)

Last Name: _____ First Name: _____ MI: _____

Gender: Male Female Birth date: ____/____/____ Social Security Number: ____-____-____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Height: Feet: ____ Inches: ____ Weight: ____ Marital Status: Single Divorced Married Separated Tobacco Use: Yes No

Work Phone: ____-____-____ Home Phone: ____-____-____

C FAMILY MEMBERS TO BE COVERED OR DELETED

Add Delete

Last Name: _____ First Name: _____ MI: _____

Gender: Male Female Student/Disabled: Student Disabled Birth date: ____/____/____ Social Security Number: ____-____-____

Out of Area Dependent: Yes No Tobacco Use: Yes No Relationship: Spouse Child Height: Feet: ____ Inches: ____ Weight (lbs): ____ Zip Code: _____

Enrollee Name: _____

E	WAIVER (If applicable)
<p>I have declined to apply for coverage for <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents. Reason for waiving: <input type="checkbox"/> Other health coverage <input type="checkbox"/> Spousal coverage <input type="checkbox"/> Other reason (please explain): _____</p> <p>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. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after a marriage, adoption or placement for adoption, and within 90 days after a birth. 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 and a pre-existing condition exclusion period may apply.</p>	
Employee Signature (only if you are waiving coverage) _____ Date: _____	

F	HEALTH INFORMATION (Used for rating purposes only. Incomplete answers could delay the decision on your request for coverage.)	
<p>Please provide the health history for the last 5 years for you and any other family members applying for coverage on this enrollment form. This includes but is not limited to, all of the listed conditions as well as any condition(s) which would have caused an ordinary prudent person to seek medical advice, diagnosis, care, or treatment as well as a condition for which medical advice, diagnosis, care or treatment was recommended or received.</p> <p>Please check <input checked="" type="checkbox"/> all applicable Yes/No responses. Circle all conditions that apply and give further details in the appropriate section indicated below.</p>		
1) AIDS, HIV, arthritis, bleeding, or clotting disorders, cancer, diabetes, disorder of the neck/back/spine, heart conditions, intestinal conditions, kidney (stones or failure), liver (cirrhosis, Hepatitis A, B, C, or D), lung conditions, organ transplant, stroke or vascular (blood vessel) disorders, tumor, alcohol or substance abuse, or mental or nervous disorders? Circle all that apply and give full details below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2) Any surgery or medical treatment discussed, planned, or recommended, that has not yet been done?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3) Currently pregnant, an expectant or surrogate parent, or in the process of adopting a child? (If yes, please include expected delivery date below.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4) Any medical conditions which have not been disclosed above? <i>(Please give full details below.)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5) Currently taking any medication? <i>(Please give full details and provide the condition for which the medication is needed below.)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I understand that for questions above that if I have failed to provide complete and accurate health information that this could result in re-rating of my entire employer group's health insurance premium or rescission (termination) of my coverage. Please initial: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please give full details for all YES answers above. If necessary, attach a signed and dated sheet with additional medical information.

Question #	Person's Name	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please Explain:
Question #	Person's Name	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please Explain:
Question #	Person's Name	Condition (Include treatment and/or operations)
Start Date: (Mo/Yr) End Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please Explain:

G AUTHORIZATION AND AGREEMENT

I hereby make the following authorizations for myself and for any of my dependents who are under the age of eighteen (18) and who are applying for coverage hereunder:

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, Intelliscript, health plan, insurance company, Medical Information Bureau, third party administrator, claims administrator, employer, governmental agency, or other person or firm to disclose my (or my dependents') personal health information and other non-medical information (including but not limited to copies of records concerning advice, diagnosis, prognosis, treatment, prescription and/or payment information relating to physical or mental illness, including without limitation, information relating to acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), AIDS related complex (ARC), or the use of drugs or alcohol) to Coventry Health Care of Louisiana, Inc. and to Coventry Health and Life Insurance Company, Inc. (collectively referred to as "Coventry") and to Coventry's authorized representatives and affiliates.

I authorize Coventry to research and review its own records for information related to my health. I understand information obtained with my authorization may be re-disclosed by Coventry as permitted or required by law and in some instances may no longer qualify for protection under Federal and state privacy laws. I understand that my authorization is voluntary and that such information will be used by Coventry for the purpose of evaluating my employer group's application for health insurance. I understand that no action will be taken on my health information without my signed authorization.

I authorize Coventry to use or disclose the information I provide (or that Coventry has or received from third parties) for purposes of administering my health insurance benefits. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) or such shorter period required by law. Any revocation will not affect the activities of Coventry prior to the date revocation is received by Coventry.

I understand that 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 is guilty of a crime and may be subject to fines or confinement in prison.

I UNDERSTAND AND AGREE THAT I MUST PERSONALLY BEAR ALL COSTS IF I USE HEALTH CARE SERVICES OR PURCHASE DRUGS AND DO NOT FOLLOW COVENTRY'S PRIOR AUTHORIZATION REQUIREMENTS.

I understand that I or my authorized representative may receive a copy of this Authorization and Agreement upon request.

H I HAVE READ AND AGREE TO THE STATEMENTS ABOVE.

Employee Signature:	Employee Printed Name:	Date:
Spouse's Signature:	Spouse's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:
Dependent's Signature (over age 18):	Dependent's Printed Name:	Date:

INCOMPLETE FORMS WILL BE RETURNED TO YOU. THIS COULD RESULT IN DELAYED ID CARD(S), DENIED CLAIMS, OR EVEN LACK OF COVERAGE. PLEASE MAKE SURE YOUR FORM IS COMPLETE BEFORE YOU SUBMIT IT.

TREATMENT OF GENETIC INFORMATION

A. Non-Discrimination Policy

Coventry will not take any of the actions listed below based on: (1) its knowledge of any Genetic Information concerning an Employee or an Employee's family member; (2) its knowledge of an Employee's or Employee's family member's request for, or receipt of, genetic services; (3) its knowledge of an Employee's or an Employee's family member's refusal to submit to a Genetic Test or to make available the results of a Genetic Test.

- Terminate, restrict, limit, or otherwise apply conditions to the coverage of the Employee or family dependent of the Employee under the Policy.
- Cancel, or refuse to renew, the coverage of the Employee or family dependent.
- Deny coverage or exclude the Employee or family dependent from coverage.
- Impose a rider that excludes coverage for certain benefits or services.
- Establish different premium rates or cost sharing for coverage.
- Otherwise discriminate against an individual or family member in the provision of insurance.

The term "Genetic Information" as used above means all information about a person's genes, gene products, inherited characteristics, family history, or family pedigree. The term "Genetic Test" as used above means any test for determining the presence or absence of Genetic Characteristics in a person. A "Genetic Characteristic" is any gene or chromosome alteration of a gene or chromosome, that is scientifically or medically believed to cause a disease, disorder, or syndrome to be associated with a statistically significant increased risk of development of a disease, disorder, or syndrome.

B. Consent to Obtain Genetic Information

Coventry must receive an Employee's or family dependent's written and informed consent, or a written and informed consent of his or her representative, before obtaining Genetic Information from an Employee or a family dependent or from a sample of his or her DNA.

Coventry will provide a copy of the written consent to the Employee. The written consent may be revoked or amended, in whole or in part, at any time. Coventry will not treat a general authorization for a release of medical records or medical information as a written consent for the disclosure of Genetic Information. The authorization shall be invalid if it is used for any purpose other than the described purpose for which disclosure is made.

C. Ownership of Genetic Information

An Employee's or family dependent's Genetic Information is the property of the Employee or family dependent and is not the property of Coventry or its representatives.

ADDITIONAL DEPENDENTS FORM (continued from Section C)

<input type="checkbox"/> Add	Last Name	First Name	MI
<input type="checkbox"/> Delete			
Gender	Student/Disabled	Birth date	Social Security Number
<input type="checkbox"/> Male	<input type="checkbox"/> Student		
<input type="checkbox"/> Female	<input type="checkbox"/> Disabled	Height	
Out of Area Dependent	Tobacco Use	Feet : Inches:	Weight (lbs):
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Zip Code:

<input type="checkbox"/> Add	Last Name	First Name	MI
<input type="checkbox"/> Delete			
Gender	Student/Disabled	Birth date	Social Security Number
<input type="checkbox"/> Male	<input type="checkbox"/> Student		
<input type="checkbox"/> Female	<input type="checkbox"/> Disabled	Height	
Out of Area Dependent	Tobacco Use	Feet : Inches:	Weight (lbs):
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Zip Code:

<input type="checkbox"/> Add	Last Name	First Name	MI
<input type="checkbox"/> Delete			
Gender	Student/Disabled	Birth date	Social Security Number
<input type="checkbox"/> Male	<input type="checkbox"/> Student		
<input type="checkbox"/> Female	<input type="checkbox"/> Disabled	Height	
Out of Area Dependent	Tobacco Use	Feet : Inches:	Weight (lbs):
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Zip Code:

<input type="checkbox"/> Add	Last Name	First Name	MI
<input type="checkbox"/> Delete			
Gender	Student/Disabled	Birth date	Social Security Number
<input type="checkbox"/> Male	<input type="checkbox"/> Student		
<input type="checkbox"/> Female	<input type="checkbox"/> Disabled	Height	
Out of Area Dependent	Tobacco Use	Feet : Inches:	Weight (lbs):
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Zip Code:

<input type="checkbox"/> Add	Last Name	First Name	MI
<input type="checkbox"/> Delete			
Gender	Student/Disabled	Birth date	Social Security Number
<input type="checkbox"/> Male	<input type="checkbox"/> Student		
<input type="checkbox"/> Female	<input type="checkbox"/> Disabled	Height	
Out of Area Dependent	Tobacco Use	Feet : Inches:	Weight (lbs):
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Zip Code:

Enrollee Name: _____

ADDITIONAL MEDICAL DETAILS (continued from Section F)

Question #	Person's Name	Condition (Include treatment and/or operations)	
Start Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
End Date: (Mo/Yr)		If Yes, Please Explain:	
Question #	Person's Name	Condition (Include treatment and/or operations)	
Start Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
End Date: (Mo/Yr)		If Yes, Please Explain:	
Question #	Person's Name	Condition (Include treatment and/or operations)	
Start Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
End Date: (Mo/Yr)		If Yes, Please Explain:	
Question #	Person's Name	Condition (Include treatment and/or operations)	
Start Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
End Date: (Mo/Yr)		If Yes, Please Explain:	
Question #	Person's Name	Condition (Include treatment and/or operations)	
Start Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
End Date: (Mo/Yr)		If Yes, Please Explain:	
Question #	Person's Name	Condition (Include treatment and/or operations)	
Start Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
End Date: (Mo/Yr)		If Yes, Please Explain:	
Question #	Person's Name	Condition (Include treatment and/or operations)	
Start Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
End Date: (Mo/Yr)		If Yes, Please Explain:	
Question #	Person's Name	Condition (Include treatment and/or operations)	
Start Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
End Date: (Mo/Yr)		If Yes, Please Explain:	
Question #	Person's Name	Condition (Include treatment and/or operations)	
Start Date: (Mo/Yr)	List all Medications Taken (Oral, Injectable, Infusion, Inhaled)	Is Ongoing Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
End Date: (Mo/Yr)		If Yes, Please Explain:	