Medical Enrollment/Change Form 2-50

COVENTRY Health Care An Aetna Company

COVENTRY Health and Life Insurance Company

Fax Medical Enrollment/Change to 877-554-9143

A EMPLOYER INFORMATION: To be completed by Employer

☐ New Group ☐ New Enrollment ☐ Change

Company Name:	*Medical Subgroup No.
*Date of Hire Full-Time: (mm/dd/yyyy) ________/___________/___________	*Medical Effective Date of Coverage or Change: ________/________/________

****Reason for Enrollment**

☐ New Group ☐ New Hire
☐ COBRA ☐ Retired
☐ Open Enrollment ☐ Qualifying Event (Reason)
Date ______/________/_______ (mm/dd/yyyy)
____

****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 per week: __________________ ☐ Other: ___________________________________

B EMPLOYEE INFORMATION

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS:	☐ Medical Plan Name:

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

*PCP Provider No. (If Applicable)			PCP Provider Name (If Applicable)			
*Last Name			*First Name			MI
*Gender ☐ Male ☐ Female	*Birthdate (mm/dd/yyyy) ______/_______/______	*Social Security Number	Marital Status (please check one): ☐ Single/Widowed ☐ Married ☐ Divorced ☐ Separated			
*Address			*City	*State	*Zip Code	
*Email Address		Home Phone	Work Phone	Height	Weight	

v Smoke or tobacco use in last 6 months? ☐ Yes ☐ No

C FAMILY MEMBERS TO BE COVERED OR DELETED

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

☐ **Add** ☐ **Delete**	**Medical** ☐	*PCP Provider No. (If Applicable)	PCP Provider Name (If Applicable)	
*Last Name			*First Name	MI
*Gender/*Relationship ☐ Male ☐ Female ☐ Spouse ☐ Child ☐ Other: ____________	Student/Disabled ☐ Student ☐ Disabled	*Birthdate (mm/dd/yyyy) ________/___________/___________	*Social Security Number Height / Weight	
v Smoke or tobacco use in last 6 months? ☐ Yes ☐ No			Primary Care Provider Current Patient? ☐ Yes ☐ No PCP #:	

☐ **Add** ☐ **Delete**	**Medical** ☐	*PCP Provider No. (If Applicable)	PCP Provider Name (If Applicable)	
*Last Name			*First Name	MI
*Gender/*Relationship ☐ Male ☐ Female ☐ Spouse ☐ Child ☐ Other: ____________	Student/Disabled ☐ Student ☐ Disabled	*Birthdate (mm/dd/yyyy) ________/___________/___________	*Social Security Number Height / Weight	
v Smoke or tobacco use in last 6 months? ☐ Yes ☐ No			Primary Care Provider Current Patient? ☐ Yes ☐ No PCP #:	

☐ **Add** ☐ **Delete**	**Medical** ☐	*PCP Provider No. (If Applicable)	PCP Provider Name (If Applicable)	
*Last Name			*First Name	MI
*Gender/*Relationship ☐ Male ☐ Female ☐ Spouse ☐ Child ☐ Other: ____________	Student/Disabled ☐ Student ☐ Disabled	*Birthdate (mm/dd/yyyy) ________/___________/___________	*Social Security Number Height / Weight	
v Smoke or tobacco use in last 6 months? ☐ Yes ☐ No			Primary Care Provider Current Patient? ☐ Yes ☐ No PCP #:	

CHCGA.EF.2-50.10-13 ***Denotes required fields for enrollment. For items with ** please select a Reason for Enrollment OR a Reason for Change.**

v 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: _____

C FAMILY MEMBERS TO BE COVERED OR DELETED

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

☐ **Add** ☐ **Delete** | **Medical** ☐ | *PCP Provider No. (If Applicable) | PCP Provider Name (If Applicable)

*Last Name | *First Name | MI

*Gender/*Relationship: ☐ Male ☐ Spouse ☐ Female ☐ Child ☐ Other: _____

Student/Disabled: ☐ Student ☐ Disabled

*Birthdate (mm/dd/yyyy): _____/_____/_____

*Social Security Number

Height | Weight

v Smoke or tobacco use in last 6 months? ☐ Yes ☐ No

Primary Care Provider | Current Patient? ☐ Yes ☐ No

PCP #:

☐ **Add** ☐ **Delete** | **Medical** ☐ | *PCP Provider No. (If Applicable) | PCP Provider Name (If Applicable)

*Last Name | *First Name | MI

*Gender/*Relationship: ☐ Male ☐ Spouse ☐ Female ☐ Child ☐ Other: _____

Student/Disabled: ☐ Student ☐ Disabled

*Birthdate (mm/dd/yyyy): _____/_____/_____

*Social Security Number

Height | Weight

v Smoke or tobacco use in last 6 months? ☐ Yes ☐ No

Primary Care Provider | Current Patient? ☐ Yes ☐ No

PCP #:

D OTHER INSURANCE

When coverage with Coventry Health Care of Georgia 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.**

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

Other Insurance Company Name | Policy Holder Name | Covered Dependents

Gender: ☐ Male ☐ Female

Relationship: ☐ Spouse ☐ Child ☐ Other: _____

Birthdate (mm/dd/yyyy): _____/_____/_____

Effective Date of Other Insurance (mm/dd/yyyy): _____/_____/_____

Other Insurance Company Name | Policy Holder Name | Covered Dependents

Gender: ☐ Male ☐ Female

Relationship: ☐ Spouse ☐ Child ☐ Other: _____

Birthdate (mm/dd/yyyy): _____/_____/_____

Effective Date of Other Insurance (mm/dd/yyyy): _____/_____/_____

Medicare Information

☐ **Subscriber or** ☐ **Dependent**

Effective Date of: (mm/dd/yyyy)

Part A _____/_____/_____

Part B _____/_____/_____

Part D _____/_____/_____

Dependent's Last Name

Dependent's First Name | MI

Medicare No.

Reason for Medicare Eligibility

☐ Over 65
☐ Disabled
☐ Kidney Disease (ESRD)
☐ ALS (Lou Gehrig's Disease)

☐ **Subscriber or** ☐ **Dependent**

Effective Date of: (mm/dd/yyyy)

Part A _____/_____/_____

Part B _____/_____/_____

Part D _____/_____/_____

Dependent's Last Name

Dependent's First Name | MI

Medicare No.

Reason for Medicare Eligibility

☐ Over 65
☐ Disabled
☐ Kidney Disease (ESRD)
☐ ALS (Lou Gehrig's Disease)

***Denotes required fields for enrollment.**

*Applicant Name: _____

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/COL.

_____ _____

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

F AGREEMENT AND AUTHORIZATION Please read the following carefully.

Conditions of Enrollment and Agreement and Authorization

1. **I hereby enroll for benefits for the person(s) listed on this form, and agree that I and my family members shall abide by the provisions of coverage set forth in the Certificate of Coverage/Insurance under which we are enrolled.**
2. **I understand** that the Certificate of Coverage/Insurance will determine the rights and responsibilities of Member(s) and Coventry Health Care of Georgia, Inc./Coventry Health and Life Insurance Company (Coventry), and will govern in the event of conflict with other materials provided by my employer or Coventry.
3. **I understand** that any act that constitutes fraud or intentional misrepresentation of a material fact in answering the questions on this application or nonpayment of premium may result in termination of coverage, or may result in a re-rating of the employer group.
4. **I understand** that the effective date of coverage shall be determined by my employer according to the guidelines established between my employer and Coventry.
5. **I authorize** any physician, hospital, other medical provider, and persons or organizations involved in utilization review, peer review and other plan administrative duties to disclose to Coventry any medical information relating to the individuals listed on this form. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through Coventry. For underwriting purposes, this authorization is valid for thirty months from the date this form is signed.
6. **I understand** that all covered medical services must be performed or authorized by the Member's Primary Care Provider or Coventry and be obtained from a participating provider unless otherwise authorized by Coventry.
7. **I authorize** deductions from my earnings of the required contribution, if any, toward the cost of Coventry coverage (if applicable).
8. **I understand** that it is my responsibility to report to my employer any changes in the eligibility of the individuals listed or any change to the information I have provided on this form.
9. **I understand** that enrollment is effective upon acceptance by Coventry and will remain in effect until the employer's next open enrollment period, regardless of the continued participation of a particular provider.
10. **I understand** that coverage and benefits are contingent upon prompt payment of premiums.
11. **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**
12. **On behalf of myself and my enrolled dependents, I authorize Coventry to use or disclose to third parties the information contained in this enrollment form for purposes of administering health insurance benefits including treatment, payment, or health care operations, as those terms are explained in detail in Coventry's Notice of Privacy Practices and to the extent permitted by law.**
13. **This health plan policy may not cover all your health care expenses. Read your Certificate of Coverage/Insurance carefully to determine which health care services are covered. If you have questions, call 800-395-2545.**

Acknowledgement Form

I understand I am enrolling in a health care plan which may require that health care services be provided by participating providers. I also understand that failure to use a participating provider may result in reduced coverage or no coverage for services I receive, and I will be fully responsible for any and all costs not covered by Coventry Health Care of Georgia, Inc./Coventry Health and Life Insurance Company (Coventry). I understand that my Certificate of Coverage/Insurance provides additional details explaining the use of participating and non-participating providers under the plan.

I have received a list of the participating providers. I understand that a provider's participating status may change from time to time and it is my responsibility to verify the provider's participation status prior to receiving services. I understand that I may verify provider status in one of two ways. First, by checking Coventry's website (**www.chcga.com**), which is updated at least every 30 days. Second, I may call Customer Service at the number listed on my Member ID card.

As required by the State of Georgia, Coventry provides the following summary of financial arrangements with the health care providers who are participating in the Coventry network:

(1) Hospital providers are paid according to a contract that includes inpatient per diems, case rates and discounted fee for service arrangements depending on a specific service provided.

(2) Physicians are paid through capitation or discounted fee for service in accordance with a specific fee schedule which has been provided to them as contracted.

(3) Laboratory services are provided through a capitulated per Member per month flat fee. Other ancillary services including home health, skilled nursing and hospice are paid on a contracted fee schedule.

I HAVE READ AND AGREE TO THE STATEMENTS ABOVE. (signature required below)

***Applicant Signature** ***Date**

***Applicant Printed Name**

1 HMO and POS plans are underwritten by Coventry Health Care of Georgia. 2 PPO plans are underwritten by Coventry Health and Life Insurance Company.
▲ Complete if required. PCP ID is found in the Provider Directory or at **www.chcga.com**.