



Enrollment Application

for small groups (with 1-50 eligible employees)

Please complete using black ink. Initial all corrections.
All questions must be answered.

Member Status Change		
<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> Waiving coverage	<input type="checkbox"/> Benefit change
<input type="checkbox"/> Special Enrollment*	<input type="checkbox"/> COBRA*	
<input type="checkbox"/> Late Enrollment	<input type="checkbox"/> Additions*	
Reason waiving coverage _____		

*Complete Qualifying Event box below.		

Effective Date of Coverage	Employer / Group Name	Group Number	Benefits Admin Initials
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Employee Information							
Social Security Number / / / / / / / /	Last Name	First Name	M.I.	Height	Weight		
Address		Apt.	City	State	Zip Code		
Mailing Address (if different than above)		Apt.	City	State	Zip code		
Home Telephone Number ()	Work Telephone Number ()	E-Mail Address		Birth Date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Date of Hire / /	Qualifying Event Event date: <input type="checkbox"/> Marriage** <input type="checkbox"/> Adoption** <input type="checkbox"/> Legal Guardianship** <input type="checkbox"/> Other	**include legal documentation				Product Selection MHS #:	

Other Health Coverage
Will you or any of your dependents be covered by any other health coverage, including Medicare or Medicaid on the day your coverage begins? Yes (attach proof) No

If yes, indicate names of those to be covered: _____ Effective Date: _____ Policy #: _____

Insurance Co. Name: _____ Insurance Co. Address: _____ Insurance Co. Telephone #: _____

Prior Health Coverage
Have you been covered by any other health coverage within the last 12 months (or 24 months for late enrollees)? Yes No (If yes, Certificates of Creditable Coverage will be requested.)

Family Information
For dependent coverage, list each dependent below. Indicate additional dependents on a separate sheet. Except for dependents pursuing a full-time student status at an educational institution, college, university, vocational or secondary school, dependents must maintain their primary residence in Coventry's service area, or the dependent is not eligible for coverage. If dependent is unmarried and age 19 or older, attach proof of (a) dependent status by providing a copy of your last IRS 1040 form, and (b) if student: a letter from registrar's office certifying current hours enrolled; or (c) if not a student but living in household: proof of legal residence (driver's license, etc); or (d) disabled: a physician's certification stating date and degree of disability.

***If a dependent who is eligible for coverage has a different last name than that of the employee, you must attach copies of supporting documentation showing evidence of his/her dependent status (birth certificate, court order for guardianship, marriage certificate, etc.).

1	Dependent Last Name (if different***)				First Name	M.I.
	Birth Date / /	Height	Weight	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to applicant: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
2	Dependent Last Name (if different***)				First Name	M.I.
	Birth Date / /	Height	Weight	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to applicant: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
3	Dependent Last Name (if different***)				First Name	M.I.
	Birth Date / /	Height	Weight	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to applicant: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
4	Dependent Last Name (if different***)				First Name	M.I.
	Birth Date / /	Height	Weight	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to applicant: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
5	Dependent Last Name (if different***)				First Name	M.I.
	Birth Date / /	Height	Weight	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to applicant: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

Social Security Number / / / / / / / / /	Last Name	First Name	M.I.	Height	Weight
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Section 1. Statement of Health (Please answer completely. Incomplete answers could delay the decision on your request for coverage.)
 Please provide the health history for yourself and other family members applying for coverage on this application. Please CHECK all applicable Yes/No responses, CIRCLE past/current condition(s), and provide corresponding details in the appropriate section. Have you or any Applicant been diagnosed, treated or advised to have treatment by a medical professional in the past 5 years for any of the following conditions/ including but are not limited to the following:

	YES	NO		YES	NO
1. Cancer, tumor, or cyst			13. Sleep apnea or disease of the throat, ears, nose, sinuses, or eyes (except glasses)		
2. Epilepsy, stroke, or paralysis			14. Arthritis, joint pain, lupus, fibromyalgia, fractures, or limb loss vasculitis, or peripheral vascular disease		
3. Head or spinal injuries, Muscular Dystrophy, Cerebral Palsy, or Multiple Sclerosis			15. Hepatitis Type: A, B, C, D or autoimmune hepatitis (Please circle) OR any other liver disorder/disease		
4. Neck or back pain, disorders of the spine, or disk herniation/bulge			16. Any drug or alcohol problems (Please give full details below to include any treatment or rehab)		
5. Any blood disorder (such as: anemia, sickle cell, or hemophilia)			17. Any organ transplant (planned, recommended, or already performed)		
6. Bladder, kidney (kidney failure or dialysis), prostate, testicular, uterine, or breast conditions			18. Is any female to be covered currently pregnant? Due Date: _____ (Month/day/year)		
7. Ulcerative colitis, Crohn's, diverticulitis, stomach ulcers, acid reflux, hernia, gallbladder, or rectal disorders			19. Cigarette or tobacco use? If YES, type of product and how much per day _____		
8. Emphysema, COPD, Cystic Fibrosis, or any other lung/respiratory disorder			20. Any hospitalizations in the last 5 years (Please give full details below)		
9. Diabetes? Type I or II (please give full details below)			21. Any future surgeries discussed, planned, or recommended (Please give full details below)		
10. Heart disease, irregular heartbeat, heart murmur, regurgitation, chest pain, congestive heart failure, or heart valve conditions			22. Currently taking any prescription medications (Please give full details below)		
11. Have you or any Applicant ever tested positive for Human Immunodeficiency Virus (HIV) or been diagnosed as having Aids Related Complex/Conditions (ARC), Acquired Immunodeficiency Syndrome (AIDS) or any other medical condition / disorder derived from such infection or immunodeficiency?			23. Are there any other medical conditions not listed above (Please give full details below)		
12. thyroid, pituitary, pancreas, glandular, or disorder requiring growth hormones					

Section 2. Provide details to all checked/circled answers in the space below by question # or as otherwise required in the Statement of Health. If more space is needed, please attach a separate sheet of paper detailing the same format as below, sign and date the paper.

Question Number	Applicant's Name	Illness / Condition Treated or Results of Physical Exam	1 st Date of Treatment or Exam	Last Date of Treatment or exam	Drugs and Dosage Prescribed	Degree of Recovery (i.e. 50%, 75%, 100%)	Treating physician's Name, Address and Phone Number

Social Security Number / / / / / / / / /	Last Name	First Name	M.I.	Height	Weight
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Election of Coverage and Authorization

I authorize any licensed physician, hospital, health care provider, insurer or any other medical or insuring entity in possession of my and my dependents' medical records and information, including any and all mental health records and information, to release my medical records and information and those of my dependents to the physician and Coventry. I hereby provide Coventry with consent to use identifiable information for general treatment, payment or health care operations, including but not limited to, coordination of care, quality assessment, utilization review, fraud detection or accreditation purposes. If member identifiable information is to be used for any other purpose, Coventry will obtain specific authorization from me and my dependents as required. I understand that newborns and adopted children, if adopted before the age of eighteen, are not subject to a pre-existing condition waiting period, if enrolled within 30 days but not later than 63 days after birth, adoption or placement. I certify that all information and statements furnished by me are true and complete to the best of my knowledge. I understand that any misrepresentation or omission of any information including pre-existing conditions may result in the termination of mine or my dependent's coverage. I understand that I am financially liable for any charges incurred after the effective date to termination of coverage. I hereby acknowledge Coventry's right to require proof of any dependent's or spouse's or child's dependent status. I understand that Coventry does not directly employ any participating providers or facilities. All health care providers and facilities are independent contractors and are not the agents or employees of Coventry. I agree that if my dependents or I have not been continuously covered by creditable coverage within the last 12 months (18 months for late enrollees), as applicable, my dependents and I, as applicable, may be subject to a pre-existing condition exclusion. I certify that I maintain my primary residence in Coventry's service area or am regularly employed in the Coventry service area. I also certify that, except for dependents pursuing a full-time student status at an accredited institution, college, university, vocational or secondary school, dependents must maintain their primary residence in Coventry's service area and dependent children are dependent on me for support and maintenance. The Certificate of Insurance (or "Contract") can be obtained through (i) the Coventry website at www.CHCFloida.com, (ii) by contacting your Group Benefit Administrator, or (iii) by calling the Coventry Customer Service Department at 1-866-550-1186 and requesting a hard copy of the Contract be mailed via U.S. regular mail. Your signature on this application represents acceptance of these delivery options.

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree. Coventry may terminate coverage of any member who knowingly defrauds Coventry.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THIS APPLICATION.

X _____
Applicant Signature

Date