COVENTRY Health Care of Nebraska, 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 (please complete sections E and F)**

Company Name: *Group No.:

Reporting Group 1: Reporting Group 2: Reporting Group 3:

Date Employed Full Time: / / *Effective Date of Coverage or Change / /

**REASON FOR ENROLLMENT:

☐ New Group ☐ New Hire
☐ Open Enrollment ☐ Retired
☐ COBRA/State Continuation (check reason below) ☐ Qualifying Event (Reason)

Date ____/____/____

**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 ☐ Retiree ☐ COBRA ☐ Salary ☐ Hourly Number of hours a week ____ ☐ Other ____

BENEFITS ADMINISTRATOR APPROVAL: **DATE:**

B SUBSCRIBER INFORMATION

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

☐ HMO ____ ☐ POS ____ ☐ PPO ____ ☐ Other ____

Type of Coverage: ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren)

*Last Name *First Name MI *Gender ☐ Male ☐ Female

*Address

*City *State *Zip Code

Email Address *Birthdate / /

Height Weight Marital Status (please check one.) ☐ Single/Widowed ☐ Divorced ☐ Married ☐ Separated *Social Security Number - -

Work Phone - - Home Phone - -

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 Birthdate / / Height Weight Relationship ☐ Spouse ☐ Child ☐ Other ____

*Social Security Number - - Resides with Subscriber: ☐ Yes ☐ No Student/Disabled: ☐ Student ☐ Disabled

☐ Add ☐ Delete *Last Name *First Name MI

*Gender: ☐ Male ☐ Female Birthdate / / Height Weight Relationship ☐ Spouse ☐ Child ☐ Other ____

*Social Security Number - - Resides with Subscriber: ☐ Yes ☐ No Student/Disabled: ☐ Student ☐ Disabled

Applicant Name: ______________________________

☐ Add ☐ Delete

*Last Name | *First Name | MI

*Gender: ☐ Male ☐ Female

Birthdate __/__/____ | Height | Weight

Relationship: ☐ Spouse ☐ Child ☐ Other ______

*Social Security Number ___-__-____

Resides with Subscriber: ☐ Yes ☐ No

Student/Disabled: ☐ Student ☐ Disabled

☐ Add ☐ Delete

*Last Name | *First Name | MI

*Gender: ☐ Male ☐ Female

Birthdate __/__/____ | Height | Weight

Relationship: ☐ Spouse ☐ Child ☐ Other ______

*Social Security Number ___-__-____

Resides with Subscriber: ☐ Yes ☐ No

Student/Disabled: ☐ Student ☐ Disabled

☐ Add ☐ Delete

*Last Name | *First Name | MI

*Gender: ☐ Male ☐ Female

Birthdate __/__/____ | Height | Weight

Relationship: ☐ Spouse ☐ Child ☐ Other ______

*Social Security Number ___-__-____

Resides with Subscriber: ☐ Yes ☐ No

Student/Disabled: ☐ Student ☐ Disabled

D OTHER MEDICAL AND/OR PHARMACY COVERAGE INFORMATION

*When coverage with Coventry Health Care 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

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**

Effective Date Of:

Part A __/__/____

Part B __/__/____

Part D __/__/____

Dependent's Last Name

Dependent's First Name | MI

Medicare #

Reason for Medicare Eligibility

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

☐ **Subscriber or** ☐ **Dependent**

Effective Date Of:

Part A __/__/____

Part B __/__/____

Part D __/__/____

Dependent's Last Name

Dependent's First Name | MI

Medicare #

Reason for Medicare Eligibility

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

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)

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 medical 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, birth, adoption or placement for adoption. 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 preexisting condition exclusion period may apply.

F AGREEMENT AND AUTHORIZATION Please read the following carefully.

I represent the above information to be complete and accurate to the best of my knowledge. I understand that my answers to the questions contained in this enrollment form (with the exception of Section D) will be used to determine eligibility for coverage. I further understand that if any material information is omitted, it could provide the basis to refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force.

I agree to the following terms for myself and my dependent(s): We authorize, if permitted by law, health care providers, insurers, claim administrators and employers to provide medical, employment and benefit information, including information relating to drug, alcohol or psychiatric histories and treatment, to Coventry Health Care or their authorized representatives. Coventry Health Care or their authorized representatives may share in such information and provide it to their insurers, claim administrators, insurers or other provider organizations only for the purpose of administering group coverage and claims for benefits, utilization review, analytical or research purposes, risk management, provider peer review or the resolution of grievances. This authorization shall be valid for twenty-four (24) months from the signature date below. I agree that a reproduced copy of this authorization will be as valid as the original. I acknowledge that I have obtained a copy of this authorization. I authorize my employer to deduct from my earnings any required contributions.

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 MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

I HAVE READ AND AGREE TO THE STATEMENTS ABOVE. (Signature Required Below)

Applicant Signature **Date**

Applicant Printed Name

Coventry Health Care products are underwritten or administered by:
Coventry Health Care of Nebraska, Inc.
• HMO & POS Plans
Coventry Health and Life Insurance Company
• PPO Plans