

\* 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

Company Name: \_\_\_\_\_ \*Group No.: \_\_\_\_\_

Date of Hire Full Time: \_\_\_\_/\_\_\_\_/\_\_\_\_ \*Effective Date of Coverage or Change: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*\*REASON FOR ENROLLMENT:**

New Group       New Hire  
 COBRA       Retired  
 Open Enrollment       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     COBRA     Salary     Hourly    Number of hours a week \_\_\_\_\_     Other \_\_\_\_\_

**B EMPLOYEE INFORMATION**

**I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS:**  
 \_\_\_\_\_

**Type of Coverage:**     Employee     Employee/Spouse     Employee/Children     Family

\*Last Name \_\_\_\_\_ \*First Name \_\_\_\_\_ MI \_\_\_\_\_

\*Gender      \*Birthdate      \*Social Security Number  
 Male     Female    \_\_\_\_/\_\_\_\_/\_\_\_\_    \_\_\_\_-\_\_\_\_-\_\_\_\_

\*Address \_\_\_\_\_

\*City \_\_\_\_\_ \*State \_\_\_\_\_ \*Zip Code \_\_\_\_\_

Email Address \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Marital Status (please check one.)  
 Single/Widowed     Married     Divorced     Separated

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 employee, please attach that information on a separate sheet of paper.

Add     Delete    \*Last Name \_\_\_\_\_ \*First Name \_\_\_\_\_ MI \_\_\_\_\_

\*Gender    \*Relationship    Student / Disabled    \*Birthdate    Social Security Number  
 Male     Spouse     Student    \_\_\_\_/\_\_\_\_/\_\_\_\_    \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Female     Child     Disabled    Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Other    \_\_\_\_\_

Add     Delete    \*Last Name \_\_\_\_\_ \*First Name \_\_\_\_\_ MI \_\_\_\_\_

\*Gender    \*Relationship    Student / Disabled    \*Birthdate    Social Security Number  
 Male     Spouse     Student    \_\_\_\_/\_\_\_\_/\_\_\_\_    \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Female     Child     Disabled    Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Other    \_\_\_\_\_





**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 1-800-395-2545.**

**Acknowledgment 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](http://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 capitated 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)**

<b>Applicant Signature</b>	<b>Date</b>
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**Applicant Printed Name**

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



# Request for Waiver of Group Medical Coverage

This form is to be used for declining Medical coverage only. If you wish to decline other coverage(s), you will also need to complete the standard waiver or enrollment form.

Firm Name: \_\_\_\_\_ Acct. Number: \_\_\_\_\_

Employee: \_\_\_\_\_ ID Number: \_\_\_\_\_

I hereby certify that I have been given an opportunity to apply for group coverage issued by Coventry Health Care, Inc. I understand the coverage available and I decline medical coverage.

Check proper boxes to decline coverage.

I decline Medical Coverage

- For Myself
- For My Spouse
- For My Children
- For My Spouse and Children

Name of Spouse \_\_\_\_\_  
 Name(s) of Children \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Reason for Waiving Coverage

- Individual Plan
- Government Plan
- Spouse's Group Plan
- Other \_\_\_\_\_

I understand if I decline medical coverage under this plan my dependent(s) are not eligible for any coverage for which I am not insured.

Employees who decline medical coverage for themselves and or their dependents during the initial enrollment period and then, more than 31 days later, request coverage will be considered to be late enrollees. Late enrollees may be subject to an exclusion from coverage for the maximum months allowed per State regulations. However, an eligible employee will not be considered a late enrollee for employee and or dependent coverage (and coverage will not be deferred) if: (a) late enrollment is made under one of the circumstances described below; and (b) any required information or proof is furnished.

### Late Enrollees Expectations

An eligible employee will not be considered a late enrollee for employee and or dependent coverage if (a) late enrollment is made under one of the circumstances described below; and (b) any required information or proof is furnished.

1. Termination of Other Health Coverage: Request for enrollment is made within 31 days after termination of other health coverage, and (a) the employee certifies that enrollment under this plan was initially declined solely due to the other coverage; and (b) termination of the other group coverage is due to involuntary termination of employment or eligibility, the involuntary termination of the previous coverage, death of a spouse or divorce.
2. Court Order: Request for enrollment is made within 31 days after Issuance of Court Order that coverage be provided for the spouse and or minor child(ren) of a covered employee.
3. Election of Different Plan During Open Enrollment Period: The employer offers multiple health plans, and request for enrollment under this plan is made during the open enrollment period established for plan election.

I hereby acknowledge the above warning regarding the consequences of declining medical coverage at my initial enrollment. I declare that the information given on this waiver is correctly recorded, complete and true.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date