Incomplete information may delay the processing of your enrollment and/or your member ID card.

ENROLLMENT & CHANGE FORM

2 - 50 Eligible Employees

Products are underwritten by Coventry Health Care of Missouri, Inc. ("Coventry Health Care") and/or Coventry Health and Life Insurance Co. 550 Maryville Centre Drive, Suite 300, St. Louis, MO 63141

EMPLOYER INFORMATION: To Be Completed By Employer

Company Name:	Group No. (10 digits):	Date Employed Full Time:	Effective Date of Coverage:	Benefits Administrator Approval: Date:

Reason for Enrollment:	Reason for Change:	Type of Coverage:	Employee Status:
❑ New Group ❑ New Hire ❑ Open Enrollment ❑ Cobra ❑ Hardship ❑ Other:	❑ Addition ❑ Address/Phone ❑ Coverage ❑ Termination Reason & Date:______ ❑ PCP Change Reason:______ ❑ Other:______	❑ Employee ❑ Employee Spouse ❑ Employee/Children ❑ Employee/Spouse/Children ❑ Waive	❑ Hourly ❑ Salary ❑ Retired ❑ Other______

EMPLOYEE INFORMATION: To Be Completed By Employee

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

Last Name:	First Name:	MI:	Social Security Number:	Marital Status:	Product Selections (Please write in plan number):
Street Address:		Work Phone & Area Code:		❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed	❑ HMO[1]: ______ ❑ PPO[2]: ______
City:	State:	Zip Code:	Home Phone & Area Code:		[1]HMO – underwritten by Coventry Health Care of Missouri, Inc. [2]PPO – underwritten by Coventry Health and Life Insurance Company

OTHER COVERAGE ELECTIONS:

SPECIAL MISSOURI NOTICE - An enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical or religious beliefs. **The group contract holder has not purchased an optional rider for elective abortions pursuant to VAMS section 376.805.**

MEMBER INFORMATION: Family Members to be Covered and Physician Selection

All areas below must be filled out for each family member or it will delay processing enrollment. If "other" is checked, please indicate the nature of that relationship and include any appropriate legal documents. *Note: PPO members do not need to select a physician. **For HMO plans', selecting a Primary Care Physician is required.**

Relationship	Add/ Delete	Last Name	First Name	M.I.	Social Security Number	Sex	Date of Birth Month	Day	Year	Primary Care Name and I.D. Number	Current Patient	*OB-GYN Name
❑ Self	❑ Add ❑ Delete					❑ M ❑ F				Name I.D.#	❑ Y ❑ N	
❑ Husband ❑ Wife	❑ Add ❑ Delete					❑ M ❑ F				Name I.D.#	❑ Y ❑ N	
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				Name I.D.#	❑ Y ❑ N	
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				Name I.D.#	❑ Y ❑ N	
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				Name I.D.#	❑ Y ❑ N	
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				Name I.D.#	❑ Y ❑ N	

OTHER HEALTH INSURANCE INFORMATION: Complete or Write N/A			
Name of Policyholder:		Birthdate (mo/day/yr):	Social Security Number:
Name of Employer:			
Name of Insurance Company of Health & Welfare Plan:	Insurance Company Phone Number:		Effective Date:
Insurance Company Claim Address:		Insurance Policy Number:	Group Number:
List of Family Members Covered:	Covered and on Medicare:	Beneficiary Number:	Medicare A Effective Date:
			Medicare B Effective Date:

Whenever a health carrier offers a health benefit plan pursuant to this subdivision to a group contract holder as an exclusive or full replacement health benefit plan the health carrier shall offer at least one additional health benefit plan option that includes an out-of-network benefit. The decision to accept or reject the offer of the option of a health benefit plan that includes an out-of-network benefit shall be made by the enrollee and not the group contract holder.

AGREEMENT: Please read the following carefully.

1. I apply for membership in or waiver of Coventry Health Care for myself and for any eligible dependents listed. If enrolled, I authorize my employer to make deductions, if any, toward the premium cost of Coventry Health Care.
2. When enrolled, I and my eligible dependents shall abide by the provisions of coverage in the Group Enrollment Agreement, Certificate of Coverage and Benefit Riders under which we are enrolled.
3. By signing this form, I authorize my employer, & any physician, hospital, medical group or other facility providing me care, treatment or consultation, to disclose to Coventry Health Care, or receive from Coventry Health Care, any medical or claim information pertaining to the persons identified in this enrollment form receiving or applying for coverage under this plan, as may be necessary to enable Coventry Health Care to make coverage determinations, pay claims or otherwise administer plan programs, including without limitation, credentialing of physicians and as applicable, other providers, all of which shall be conducted in accordance with state and federal confidentiality laws. Coventry Health Care will not disclose any information pertaining to HIV/AIDS or chemical dependency/substance abuse except as specifically permitted by applicable law.
4. I understand and agree no benefits shall take effect until this application is approved by Coventry Health Care.
5. I understand that my membership may be cancelled for one or both of the following reasons: (1) failure to pay the amount due under the Group Enrollment Agreement or Certificate of Coverage, for which I am legally responsible, or (2) fraud and intentional misrepresentation in enrollment or in the use of services of facilities.
6. Any person who knowingly and with intent to injure, defraud or deceive 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.
7. I understand that it is my responsibility to report to Coventry Health Care any change in the eligibility of myself or my dependents.

By signing this form I certify ALL information given is true and accurate.

Applicant's Signature: _____ Date: _____

GENERAL PROVISIONS

1. **ENROLLMENT RIGHTS NOTICE (Waived Coverage) -** I understand that if I and/or any of my dependents, if any, waive coverage at this time and desire to participate in the plan at a future date, coverage could be subject to treatment as a late enrollee at that time. I further understand that even if I decline enrollment for myself or my dependents, spouse included, because of other health coverage at this time, I will still have the right to enroll myself and/or my dependents in this plan, provided I request enrollment within thirty-one (31) days of the time that such coverage ends. I also understand that if a new dependent relationship is formed due to marriage, birth, adoption, placement for adoption, or court order, I may be able to enroll myself and/or my dependents provided I request enrollment within thirty-one (31) days of such marriage, birth, adoption, placement for adoption or court order.
2. **RESOLUTION OF DISPUTES -** Please refer to the Certificate of Coverage, which outlines in detail Coventry Health Care's Member Grievance and Appeals Procedure.

FOR HEALTH PLAN USE ONLY			
Group Number:	Subscriber No.:	Date Entered/By:	Effective Date::