



\*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.

<input type="checkbox"/> Add <input type="checkbox"/> Delete	<b>Medical</b> <input type="checkbox"/>	*PCP Provider No. (If Applicable)	PCP Provider Name (If Applicable)
*Last Name		*First Name	MI
*Gender/*Relationship <input type="checkbox"/> Male <input type="checkbox"/> Spouse <input type="checkbox"/> Female <input type="checkbox"/> Child <input type="checkbox"/> Other: _____		Student/Disabled <input type="checkbox"/> Student <input type="checkbox"/> Disabled	*Birthdate (mm/dd/yyyy) ____/____/____
<input checked="" type="checkbox"/> Smoke or tobacco use in last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Provider	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
		PCP #:	

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<input checked="" type="checkbox"/> Smoke or tobacco use in last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Provider	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	Birthdate (mm/dd/yyyy) ____/____/____		Effective Date of Other Insurance (mm/dd/yyyy) ____/____/____
Other Insurance Company Name		Policy Holder Name		Covered Dependents
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	Birthdate (mm/dd/yyyy) ____/____/____		Effective Date of Other Insurance (mm/dd/yyyy) ____/____/____

**Medicare Information**

<input type="checkbox"/> <b>Subscriber</b> or <input type="checkbox"/> <b>Dependent</b>			<b>Reason for Medicare Eligibility</b> <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Kidney Disease (ESRD) <input type="checkbox"/> ALS (Lou Gehrig's Disease)
Effective Date of: (mm/dd/yyyy)		Dependent's Last Name	
Part A ____/____/____	Part B ____/____/____	Dependent's First Name	
Part D ____/____/____		MI	
		Medicare No.	

<input type="checkbox"/> <b>Subscriber</b> or <input type="checkbox"/> <b>Dependent</b>			<b>Reason for Medicare Eligibility</b> <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Kidney Disease (ESRD) <input type="checkbox"/> ALS (Lou Gehrig's Disease)
Effective Date of: (mm/dd/yyyy)		Dependent's Last Name	
Part A ____/____/____	Part B ____/____/____	Dependent's First Name	
Part D ____/____/____		MI	
		Medicare No.	

\*Applicant Name: \_\_\_\_\_

<b>E WAIVER</b> My employer has given me an opportunity to apply for group health coverage for myself and my dependents (if applicable)
<b>I have declined to apply for coverage for</b> <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents <b>Reason for decline:</b> <input type="checkbox"/> Other health insurance <input type="checkbox"/> Spousal coverage <input type="checkbox"/> 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](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)**

\*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](http://www.chcga.com).