ENROLLMENT AND CHANGE FORM *Important: * Denotes required field or section.* DO NOT WRITE IN MARGINS

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***Plan:** ☐ HMO ☐ POS ☐ PPO ☐ QHDHP **Selection (Optional):** ☐ Base ☐ Buy-up ☐ Buy-down ☐ Other: _____

*Group Name:	*Group Number:	*Effective Date / Date of Change:

***Section A – Reason for Enrollment or Change:**

	Add Dependent(s)	COBRA/State Continuation eligible due to:	Cancel All Coverage	Cancel Dependent(s) Coverage only	Reinstatement
☐ New Group	☐ Marriage	☐ Termination of employment	☐ Terminate Employment	☐ Marriage	☐ Return from Layoff
☐ New Hire	☐ Newborn	☐ Reduction in Work Hours	☐ Voluntary Withdrawal	☐ Divorce	☐ Return from leave
☐ Open Enrollment	☐ Adoption	☐ Divorce/Separation	☐ Leave/Layoff	☐ Age Limit	☐ Rehire
☐ Loss of Other Group Coverage	☐ QMCSO	☐ Loss of Eligibility	☐ Out of Service Area	☐ Out of Service Area	☐ Enrollment Error
☐ Name Change	☐ Other	☐ Death of Subscriber	☐ Other	☐ Other	☐ Other
☐ Address/Phone Change					
☐ Dependent Address Change					

***Section B – Employee Information (Please Print Clearly):**

*Last Name	*First Name	*MI	*Email Address	*Hire Date

*Address	*City, State	*Zip Code	*Phone	*Work phone

***Is the Employee on a Leave of Absence?** ☐ No ☐ Yes ***if Yes, what type:** ☐ FMLA ☐ Worker's Compensation ☐ Disability ☐ Retired

*Last Name, First Name, MI Indicate if adding or canceling coverage		*Gender	*Birth Date MM/DD/YYYY	*Social Security Number	*Status	*Relationship to Employee	*Dependent Address if different from Employee
*Employee		☐ M ☐ F			☐ Active ☐ On Leave	N/A	N/A
Spouse	☐ Add ☐ Delete†	☐ M ☐ F			☐ Common Law ** ☐ Disabled		
Child***	☐ Add ☐ Delete	☐ M ☐ F			☐ Lives with Employee ☐ Disabled		
Child***	☐ Add ☐ Delete	☐ M ☐ F			☐ Lives with Employee ☐ Disabled		
Child***	☐ Add ☐ Delete	☐ M ☐ F			☐ Lives with Employee ☐ Disabled		

** You must submit affidavit with Enrollment if indicating marriage under Common Law. ***For Dependent children eligible for Coverage under a Qualified Medical Child Support Order (QMCSO), you must submit the Medical Child Support order with Enrollment. † If applicable, submit any divorce decree and family court order so that order of benefit coordination may be determined promptly to prevent any delay in claim processing/payment.

***Section C – Coordination of Benefits**

***Other Medical/Rx Insurance Coverage:** When coverage begins, will you or any of your family members have any other insurance coverage? ☐ Yes ☐ No

If yes, check all that apply ☐ Medical ☐ RX **List type:** ☐ Commercial/Employer Group ☐ Individual Policy ☐ Medicare **What family members are covered?**

☐ Self ☐ Spouse ☐ Child(ren) If not all, list: _____

Policy Holder: _____ **Insurance Provider:** _____

Effective Date: _____ **Medicare Eligibility due to:** ☐ Age 65 ☐ Disability ☐ Other **and** Coverage includes: Part ☐ A ☐ B ☐ C ☐ D

***Section D – Agreement and Authorization**

By signing this form, I am applying for covered services for which my family and I are eligible and I authorize my employer to deduct from my earnings any required contributions. I agree on behalf of myself and those family members enrolled ("Dependents"), for whom I have the authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as my "Enrolled Family"), that Coventry Health Care of Kansas, Inc. and Coventry Health and Life Insurance Company, and/or their authorized representatives (collectively referred to as "Health Plan") may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering my health insurance benefit, including for treatment, payment or health care operations, as those terms are explained in detail in Health Plan's Notice of Privacy Practices and to the extent permitted by law.

I also agree on behalf of myself and my Dependents, that, to the extent permitted by law, health care providers, insurers, claims administrators, employers and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, autoimmune deficiency syndrome, AIDS related complex, human immunodeficiency virus or genetic conditions to Health Plan for Health Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law. This agreement shall remain valid for twenty-four (24) months.

I represent that my answers to the questions on this form are complete and accurate to the best of my knowledge, and I understand that my answers will be used to determine eligibility for coverage. If I, on behalf of myself and my Dependents, engage in gross misbehavior, intentional fraud or the making of intentional misrepresentation of material fact in applying for or seeking any benefits through the Health Plan, it could provide the basis to reform, refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force. After coverage has been in force for two years, no statement except fraudulent statements I make voids my coverage or reduces my benefits.

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.**

Employee Signature	Employee Printed Name	Date
_____	_____	_____

Employer's Authorized Representative (required if employee is not available to sign)

Signature	Printed Name and Title	Date
_____	_____	_____

INCOMPLETE FORMS WILL BE RETURNED, DELAYING ELIGIBILITY, CLAIMS PROCESSING, RECEIPT OF ID CARDS(S) AND MAY RESULT IN DENIED CLAIMS

HMO/POS Plans *underwritten by* Coventry Health Care of Kansas, Inc. PPO Plans *underwritten by* Coventry Health and Life Insurance Company.