

CoventryOne® Application / Health Statement Form

CHECK ONE
 New Enrollment Change Form

FOR INTERNAL USE ONLY
 ACH NON-ACH
 PDP: _____

A PRIMARY APPLICANT INFORMATION (Please Use Black Ink.)

LAST NAME	FIRST NAME	MI	M/F	AGE	BIRTHDATE / /	SOCIAL SECURITY NUMBER	REQUESTED EFFECTIVE DATE
RESIDENCE ADDRESS	CITY	STATE	ZIP CODE	COUNTY	HOME PHONE () -	HEIGHT (ft. in.)	WEIGHT (lbs.)
PRIMARY E-MAIL ADDRESS	OCCUPATION / TITLE	CITY	STATE	ZIP CODE	BUSINESS PHONE () -	STATE	ZIP CODE
MAILING ADDRESS (if different from above)							

Has any person listed on this application NOT resided in the U.S. for the past six (6) consecutive months? YES NO

Plan Selection – Please select the benefit plan for which you are requesting coverage:

\$20 Copay POS \$500 Ded
 \$20 Copay POS \$1,000 Ded
 \$20 Copay POS \$2,000 Ded
 \$20 Copay POS \$3,000 Ded
 \$20 Copay POS \$5,000 Ded
 \$20 Copay POS \$10,000 Ded
 Qualified High Deductible HP POS \$1,250 / \$2,500 Ded
 Qualified High Deductible HP POS \$3,000 / \$5,500 Ded
 Qualified High Deductible HP POS \$5,000 / 10,000 Ded

Mental Health Rider (Optional)
 Only available with \$20 Copay Plans

Consumer Choice Option (Optional) **Rate Quoted:** _____

B DEPENDENTS TO BE COVERED OR REMOVED FROM COVERAGE

Full Name (Last, First, MI)	Gender	Relationship	Age	Birthdate / /	Student or Disabled Dependent	Social Security Number	Height (ft. in.)	Weight (lbs)
	M / F	SPOUSE		/ /	-----			
	M / F			/ /	S / D			
	M / F			/ /	S / D			
	M / F			/ /	S / D			
	M / F			/ /	S / D			
	M / F			/ /	S / D			

C OTHER HEALTH INSURANCE

Do you or any of your dependents have other health coverage? YES NO Who is covered? Self Dependent Family

Policyholder Name: _____ Name of Insurance Company: _____ Policy # _____ Policy Eff Date / / Policy Term Date / /

If you have other health coverage, you must cancel that other health coverage upon our acceptance of your application for CoventryOne. If you do not cancel your other health coverage, we will terminate CoventryOne coverage back to your original effective date. DO NOT cancel existing insurance until you have been notified of your acceptance by CoventryOne Underwriting.

Has anyone applying for coverage been covered by Coventry Health Care of Georgia, Inc. or any other Coventry plan? YES NO

Is anyone applying for coverage covered by or eligible for coverage under Medicare? YES NO IF YES, DO NOT complete this application. Please contact your Broker.

Applicant Name: _____

HEALTH HISTORY Please check "Yes" or "No" and provide details for all "Yes" answers in Section F.33.

For any of the following conditions or diseases, has any person listed on this application within the past ten (10) years:

- had any signs or experienced symptoms that would cause an ordinary prudent person to seek advice, treatment or therapy or had treatment from a health care provider, psychotherapist or counselor, taken prescription medication,
- consulted with, or had consultation or therapy recommended by a health care provider, psychotherapist or counselor,
- been diagnosed by a health care provider, psychotherapist or counselor,
- received treatment from a health care provider, psychotherapist or counselor, and/or
- been hospitalized?

Please answer all questions. We are unable to process incomplete applications. In order to process your application additional information may be required. A CoventryOne representative may call you. You may be asked to complete a questionnaire or provide medical records. It is the responsibility of the applicant to obtain medical records at his/her own cost. Your application may be delayed or declined if requested information is not received. This list of questions is intended to be comprehensive but not all-inclusive.

1. Heart attack, heart murmur, irregular heart rate, stroke, chest pain, high blood pressure, angioplasty, heart bypass, rheumatic fever, congestive heart failure, heart or valve disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	15. Have you been treated in the emergency room, been hospitalized or had any surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Hyperlipidemia, high cholesterol, arteriosclerosis, circulatory or vascular problems, hemophilia, blood clots, anemia, blood vessels or bleeding disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	16. Manic depression, bipolar, panic attacks, attention deficit disorders, schizophrenia, obsessive-compulsive disorders (OCD), depression or behavioral disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Stomach or intestinal ulcer, colitis, Crohn's disease, Celiac disease, hernia, hepatitis, liver disease or disorder of the stomach, intestines, pancreas, rectum or gall bladder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	17. Cataracts, glaucoma, macular degeneration, retinopathy, strabismus, eye disorders, ear infections, ear disorder or hearing impairment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Cancer, cysts, polyps, tumor or growth of any kind?	Yes <input type="checkbox"/> No <input type="checkbox"/>	18. Sexually transmitted disease, abnormal pap smear or mammogram, breast disorder, disorder of male or female organs	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Disorder of the kidneys, prostate or urinary system, kidney failure, blood or albumin in urine or receiving dialysis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	19. Menstrual dysfunction? <u>Date of last menstrual cycle:</u> _____ Adult: _____ Postmenopausal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Dependent: _____ Dependent: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Tuberculosis, emphysema, cystic fibrosis, COPD, bronchitis, asthma, allergies, sleep apnea, pneumonia, pleurisy, deviated nasal septum or disorder of the lungs or respiratory system?	Yes <input type="checkbox"/> No <input type="checkbox"/>	20. Thyroid, pituitary or adrenal gland disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Epilepsy, any seizure disorder, Alzheimer's disease, fainting spells, migraines, frequent headaches, paralysis, brain or neurological disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	21. Lyme disease or any chronic infections or infectious diseases?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Lupus, fibromyalgia, arthritis, sarcoidosis, scleroderma, or disorder of the joints, muscles or bones?	Yes <input type="checkbox"/> No <input type="checkbox"/>	22. Are you, your spouse, any dependent child(ren), even if not named in this application, an expectant parent, or in the process of adoption or becoming a surrogate parent? Due date? _____ Whom? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Any bodily injury, concussion, burns, fractures, back or spinal conditions, congenital problems or defects?	Yes <input type="checkbox"/> No <input type="checkbox"/>	23. Been treated, counseled, or advised to seek treatment regarding use of alcohol, illegal substance, narcotics or prescription drugs?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Diabetes or abnormal glucose test (high / low)? Or Insulin Resistance?	Yes <input type="checkbox"/> No <input type="checkbox"/>	24. Sought or been advised to seek psychiatric, psychological or mental health treatment or counseling?	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Donor, recipient or a candidate for a transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, when? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	25. Anorexia, bulimia, gastric bypass or other eating disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Any amputations, prosthetic devices or implants?	Yes <input type="checkbox"/> No <input type="checkbox"/>	26. Had an X-ray, electrocardiogram, cardiac catheterization, MRI, CT scan, ultrasound or other diagnostic test or procedure? If "Yes" what was the purpose? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. HIV, AIDS or AIDS-related complex?	Yes <input type="checkbox"/> No <input type="checkbox"/>	27. Have you or any person applying for coverage used tobacco products in the past 12 months? If Yes, who has used tobacco products: _____ What kind? _____ Frequency: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Any neurological or muscular disorders such as Cerebral Palsy, Multiple Sclerosis, Muscular Dystrophy or Parkinson's Disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	28. Any skin disorders such as psoriasis, acne, eczema, dermatitis, herpes, shingles or severe scars?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant Name: _____

AUTHORIZATION OF RELEASE OF INFORMATION

I, for myself and any of my dependents who are under the age of 18 who and are applying for coverage hereunder, hereby make the following authorizations:

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, insurance company, claims administrator, employer, governmental agency or other person or firm, to disclose to Coventry Health Care of Georgia, Inc. or its authorized representatives (collectively referred to as "Health Plan"), my (or my dependents') personal information, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to me, including without limitation, information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or the use of drugs or alcohol. I also authorize the release of information relating to mental illness.

In addition, I authorize Health Plan to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by Health Plan for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for Health Plan to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by Health Plan as permitted or required by law and may no longer be protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request.

I authorize Health Plan to use or disclose the information I provide in this application (or that the Health Plan has or receives from third parties) for purposes of administering my health insurance benefits. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) or such shorter period required by law. Any revocation will not affect the activities of Health Plan prior to the date such revocation is received by Health Plan.

Primary Applicant's Signature _____ Date _____ Spouse's Signature (if to be covered) _____ Date _____

Dependent's Signature (if Age 18 and to be covered) _____ Date _____
If Primary Applicant is under the age of 18, this application must be signed by the applicant's parent or legal guardian:

Parent / Guardian Signature _____ Please Print Name _____ Relationship to Applicant _____ Date _____

PREMIUM PAYMENT

Premiums due for coverage under this policy will be paid from funds deducted from either your checking or savings account. This withdrawal is done with your authorization and approval, pending final medical underwriting, an approved premium and your acceptance of coverage. To facilitate the premium withdrawal we need your banking information. Providing this information does not guarantee coverage and no funds will be drawn prior to notification and acceptance by applicant.

Please Provide: Checking Account Savings Account

Name of Bank or Savings Institution: _____

9-Digit Routing Number: | | | | | | | | | |

Account Number: _____

(A voided check or savings account deposit slip should be attached in support of content in this section)

Name that appears on the Account: _____

Address on the Account: _____

Applicable Premium Payment is withdrawn on the 10th day of each month or next business day.

If your policy effective date is on the 15th of the month, the premium payment will be prorated to 1/2 of the normal monthly amount for the first 2 weeks of coverage. This means that the first premium payment withdrawal amount will pay for the first 1 1/2 months of coverage. If your policy effective date is on the 1st of the month, the first premium withdrawal may not occur until the 10th of the following month. When this happens, the first premium withdrawal will be twice the normal monthly amount to pay for both the first and second months of coverage.

Your policy/coverage will be in effect when the premium rate has been presented and accepted, medical underwriting completed and approved, and applicable premium received and applied to your account.

By signing below, I authorize Coventry Health Care of Georgia, Inc. to initiate automatic withdrawal of applicable premium payments from the account listed above. I understand that it is my responsibility to notify the plan if I change banks or account numbers.

Account Holder Signature: _____ Date: _____

NAME ADDRESS CITY STATE ZIP	0123 0123456789
DATE	_____
FOR FUTURE USE ONLY	_____
BANK NAME ACCOUNT CITY STATE ZIP	_____
ROUTING #	0123456789
ACCOUNT #	0123

Dont Forget To Sign Above

HEALTH SAVINGS ACCOUNT ("HSA") OPTION FOR QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN ONLY

Your Health Savings Account ("HSA") is your financial asset even if you change health plans or are no longer covered by CoventryOne. To open an HSA you must meet three criteria:

- (1) you must be covered by a Qualified High Deductible Health Plan (QHDHP); (2) you cannot be covered by another health plan, including Medicare; and (3) you cannot be claimed as a dependent on another individual's tax return. If you have selected a CoventryOne Qualified High Deductible Health Plan (QHDHP) and are otherwise eligible, you will receive a Health Savings Account (HSA) through our HSA trustee, HealthEquity, at no additional charge. You will be able to contribute to this tax-advantaged account to help you put aside money to fund your medical claims before meeting your deductible and save for future medical expenses. As an additional benefit, HealthEquity will provide 24/7 telephonic support and online information to help you better manage this account.
- If you have selected a CoventryOne QHDHP product and do not want to take advantage of the HSA account, please check the box below. Otherwise you will receive a welcome kit and HSA Debit Card from HealthEquity once your CoventryOne QHDHP application is accepted.

OPT-OUT of having an HSA opened through HealthEquity

J CONDITIONS OF ENROLLMENT

I represent that all information on this application form is complete and accurate to the best of my knowledge. I understand that my answers to the questions on this form will be used to determine eligibility for coverage and is the basis on which my premium rate may be determined. I further understand that if any information is omitted or intentionally misrepresented, it could provide the basis to 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. I understand that if my application for coverage is declined, I may not apply for CoventryOne coverage for six (6) months.

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.

NOTICE: YOU MUST PERSONALLY BEAR ALL COSTS IF YOU USE OUT-OF-NETWORK NON-EMERGENCY HEALTH CARE OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

ACKNOWLEDGEMENT

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"). I understand that my Individual Member Contract 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), 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:

- (a) Hospitals are paid according to a contract that includes inpatient per diems, case rates & discounted fee for service arrangements depending on the specific service provided.
- (b) 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.
- (c) 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.

Primary Applicant's Signature _____ **Date** _____

Spouse's Signature (if to be covered) _____ **Date** _____

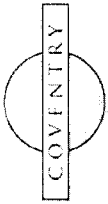
Dependent's Signature (if Age 18 and to be covered) _____ **Date** _____

If Primary Applicant is under the age of 18, this application must be signed by the applicant's parent or legal guardian:

Parent / Guardian Signature _____ **Please Print Name** _____ **Relationship to Applicant** _____ **Date** _____

K **Bro** **Christopher "Chase" Carey** **Broker ID #:** _____ **Email Addr** **Chase@CareyBA.com**

Signature of Broker: _____ **Agency Na** **CAREY Benefit Assoc.** **Agency Phone:** **770.751.6460**



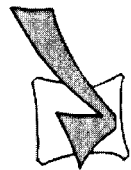
Applicant Name: _____

Check Addendum and Commonly Missed Areas Check List

Attach Voided Check Over This Box

Please Double Check These Commonly Missed Areas:

1. Above: Attach a voided check
2. Page 1, Section B: Include SS# for all people applying
3. Page 3, Section D, #19. If female, please include date of last menstrual cycle
4. Page 4, #33: If you answered "Yes" to any of Section F #s 1-32, please give details here
5. Page 5, At Bottom, have bank account holder sign and date



Broker

Christopher "Chase" Carey ~ Student Insurance Store / CAREY Benefit Associates ~ O: 770.751.6460 ~ eFax:
678.868.1892 ~ EM: Info@StudentInsuranceStore.com