

<b>FOR INTERNAL USE ONLY</b>	
EL CODE _____	
<input type="checkbox"/> ACH	<input type="checkbox"/> NON-ACH
<input type="checkbox"/> HSA OPT-OUT	<input type="checkbox"/> PDP

**To ensure timely processing of this Application:**

- ✓ Use only blue or black ink
- ✓ All questions must be answered completely and accurately
- ✓ The Application must be signed and dated in each required section by all required Applicants
- ✓ All corrections must be initialed and dated; correction fluid is not permitted
- ✓ This Application is valid sixty (60) days from the earliest date of signature in the Conditions of Enrollment section.

<b>FOR BROKER USE ONLY</b>
Amount quoted for requested effective date:
\$ _____ / Month
<b>Payroll Deduction Program (PDP)</b>
<input type="checkbox"/> Not Applicable
<b>Name of PDP</b> _____

**Check all that apply:**

- New Application     Plan Benefits Increase     Add Dependent
- Reinstatement     New Minor Child-Only Application (under 18 years old)

<b>REQUESTED EFFECTIVE DATE</b>
<input type="checkbox"/> 1 <sup>st</sup> day of _____ 20____
<input type="checkbox"/> 15 <sup>th</sup> day of _____ 20____

**APPLICANT AND DEPENDENT INFORMATION**

**PRIMARY APPLICANT** If Minor Child-Only Application, complete information about the child(ren)'s parent or legal guardian in this section.

Last name	First name			MI	Home phone ( ) -
Residence address	City	State	ZIP code	County	
E-mail address	Occupation / Title			Business phone ( ) -	
Best time and place to receive a call from Coventry regarding this Application, if necessary: <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Other (____) _____ <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening				Relationship (if Minor Child-Only Application)	
Mailing address (If different from address above)	City	State	ZIP code		

**PRIMARY APPLICANT'S SPOUSE** (If applying for coverage on this Application)

Last name	First name			MI	Home phone ( ) -
Residence address	City	State	ZIP code	County	
E-mail address	Occupation / Title			Business phone ( ) -	
Best time and place to receive a call from Coventry regarding this Application, if necessary: <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Other (____) _____ <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening					
Mailing address (If different from address above)	City	State	ZIP code		

**Applicant Name:** \_\_\_\_\_  
CHC-GA-INDV-Application-0908

**Broker:** Bill Howell

**PRIMARY APPLICANT AND ALL DEPENDENTS APPLYING FOR COVERAGE**

1. Are all persons applying for coverage in this Application legal residents of the United States?  Yes  No
2. Have all persons applying for coverage in this Application legally resided in the United States for the past six (6) consecutive months?  Yes  No

If no, indicate person(s): \_\_\_\_\_

Country of residency: \_\_\_\_\_ Date of entry into the United States (mm/yyyy) \_\_\_\_\_

3. List Primary Applicant and all Dependents applying for coverage in this Application:

Full Name (Last, First, MI)	Gender (circle one)	Relationship to the Primary Applicant	Age	Birthdate (mm/dd/yyyy)	Disabled dependent? <sup>1</sup>	Social Security Number (if available)	Height (ft. in.)	Weight (lbs)	Tobacco use? <sup>2</sup>
1.	M / F	SELF			N/A				<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	M / F	SPOUSE			N/A				<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	M / F				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	M / F				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	M / F				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	M / F				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	M / F				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No

<sup>1</sup> Please check the appropriate box if the listed dependent is disabled.

<sup>2</sup> 'Tobacco use' constitutes use of tobacco or tobacco cessation products in the past twelve (12) months. If yes, provide details in the Lifestyle Additional Information Section

4. Are all of the Primary Applicant's dependent children accounted for in this Application for coverage?  Yes  No

If no, explain: \_\_\_\_\_

5. Is anyone applying for coverage in this Application required to provide health care coverage for a child pursuant to a qualified medical child support order or other court order?  Yes  No

If yes, explain: \_\_\_\_\_

6. Do all dependent children included in this Application reside with the Primary Applicant?  Yes  No

If no, complete the Custodial Parent section below. Note that the Custodial Parent must also sign the Authorization of Release of Information and Conditions of Enrollment Sections of this Application.

Child Name (Last, First, MI)	Custodial Parent Name (Last, First, MI)	Custodial Parent Address	Relationship to child
1.			
2.			
3.			

**PLAN SELECTION**

Indicate one (1) plan selection below for which all Applicants are applying.

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> \$20 Copay POS \$ 500   | <input type="checkbox"/> \$35 Copay POS \$1,000  | <input type="checkbox"/> Fusion POS \$3,000          | <input type="checkbox"/> Mental Health Rider    |
| <input type="checkbox"/> \$20 Copay POS \$1,000  | <input type="checkbox"/> \$35 Copay POS \$2,500  | <input type="checkbox"/> Fusion POS \$5,000          |   |
| <input type="checkbox"/> \$20 Copay POS \$2,000  | <input type="checkbox"/> \$35 Copay POS \$5,000  |  | <input type="checkbox"/> Consumer Choice Option |
| <input type="checkbox"/> \$20 Copay POS \$3,000  | <input type="checkbox"/> \$35 Copay POS \$7,500  | <input type="checkbox"/> QHDHP POS \$1,250/ \$2,500  |   |
| <input type="checkbox"/> \$20 Copay POS \$4,000  | <input type="checkbox"/> \$35 Copay POS \$10,000 | <input type="checkbox"/> QHDHP POS \$3,000/ \$5,500  |   |
| <input type="checkbox"/> \$20 Copay POS \$5,000  |  | <input type="checkbox"/> QHDHP POS \$5,000/ \$10,000 |   |
| <input type="checkbox"/> \$20 Copay POS \$10,000 |  |  |   |

If plan selection is a Qualified High Deductible Health Plan (QHDHP), proceed to the Health Savings Account (HSA) Selection section if you wish to open a Health Savings Account (HSA).

Mental Health Rider is optional for \$20 or \$35 POS and Fusion Plans only, **for an additional cost**. Mental Health benefits are built into QHDHPs.

**HEALTH SAVINGS ACCOUNT (HSA) SELECTION**

This section is only applicable when the plan selected in the Plan Selection section is a Qualified High Deductible Health Plan (QHDHP). If Plan Selection is not a QHDHP, skip to the Other Health Insurance Information section.

Your Health Savings Account (HSA) is your financial asset even if you change health plans or are no longer covered by Coventry. To open an HSA, you must meet three (3) 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 "OPT-OUT" box below.** Otherwise, you will receive a welcome kit and HSA debit card from HealthEquity, subject to this CoventryOne QHDHP Application approval and acceptance.

**OPT-OUT of having an HSA opened through HealthEquity**

**OTHER HEALTH INSURANCE INFORMATION**

1. Is anyone applying for coverage in this Application covered by or eligible for coverage under Medicare?  Yes  No

If yes, list the Applicants who are covered by or eligible for coverage under Medicare as of the requested effective date.

**If so, this person(s) is not eligible for coverage** \_\_\_\_\_

2. In the past **TEN (10) YEARS**, has anyone applying for coverage in this Application:

A) Applied for a Coventry Health Care of Georgia or any other Coventry Health Care plan?  Yes  No

List the Applicants who have previously applied: \_\_\_\_\_

B) Previously been enrolled in a Coventry Health Care of Georgia or any other Coventry Health Care plan?  Yes  No

List the Applicants who have been previously enrolled: \_\_\_\_\_

C) Currently enrolled in a Coventry Health Care of Georgia or any other Coventry Health Care plan?  Yes  No

List the Applicants currently enrolled: \_\_\_\_\_

3. In the **PAST FIVE (5) YEARS**, has anyone applying for coverage in this Application had any form of life or health insurance denied, cancelled, postponed; had a waiver applied or been charged extra premium for life, disability or health insurance; or had such insurance rescinded or involuntarily terminated, restricted or rated up?  Yes  No

If yes, complete information below:

Applicant Name (Last, First, MI)	Type of insurance (circle)	Name of company	Reason
1.	Health / Life / Disability		
2.	Health / Life / Disability		
3.	Health / Life / Disability		

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

**Broker:** Bill Howell

4. Is any person applying for coverage in this Application covered by any other health insurance?  Yes  No  
 If no, skip to Creditable Coverage; Lifestyle and Health History section. If yes, continue below:

Applicant Name (Last, First, MI)	Name of Company	Type of coverage (Group, Individual, COBRA, Short-Term, etc.)	Replacing other coverage?*** (Circle one)	If yes, anticipated Policy Term Date (mm/dd/yyyy)
1.			<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.			<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No	

\*\* Is the coverage being applied for in this Application intended to replace other carrier's coverage?  
 Anyone applying for coverage in this Application having other Coventry health coverage must cancel that other health coverage upon acceptance of this CoventryOne, if offered. If other Coventry health coverage is not cancelled, this CoventryOne coverage will be terminated as of the original effective date. **DO NOT cancel existing insurance coverage until notified in writing of approval of this Application by Coventry.**

**LIFESTYLE AND HEALTH HISTORY**

Check 'Yes' or 'No,' when applicable. **Answer all questions completely.** Unanswered questions will delay or stop processing. Provide details in the Additional Information section. In order to process your Application, additional information may be required. A Coventry representative may call you to discuss your Application. You may be asked to complete a questionnaire or to provide medical records. Failure to obtain the needed information will result in our inability to process the Application.

If the health status of any Applicant herein changes between the signature date of this Application and the latter of the coverage effective date or approval date, Coventry must be notified of the change in writing.

**LIFESTYLE QUESTIONS**

1. Is anyone listed in this Application (whether applying for coverage or not) currently pregnant, an expectant or surrogate parent, or in the process of adopting a child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past <b>FIVE (5) YEARS</b> , has any person applying to be covered:	
A) Been advised to seek treatment for alcohol use or been advised to reduce alcohol intake, or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B) Been a member of any alcohol or drug support group?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C) Used any illegal drugs or substances, or controlled substance not prescribed by a doctor, or been counseled for, diagnosed with, or treated for drug or chemical use or dependence (including prescription, non-prescription, or illegal)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past <b>FIVE (5) YEARS</b> , has anyone applying for coverage in this Application been cited or convicted of driving under the influence of alcohol or any drug?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Within the past 12 months, has any person to be covered consumed alcoholic beverages? ( Note: Even if only on occasion, please provide the number of drinks consumed on such occasions.)	
Applicant Name _____ Number of drinks consumed per week: <input type="checkbox"/> 0-7 <input type="checkbox"/> 8-14 <input type="checkbox"/> 15-20 <input type="checkbox"/> 21-26 <input type="checkbox"/> 27-35 <input type="checkbox"/> 36 or more	<input type="checkbox"/> Yes <input type="checkbox"/> No
Applicant Name _____ Number of drinks consumed per week: <input type="checkbox"/> 0-7 <input type="checkbox"/> 8-14 <input type="checkbox"/> 15-20 <input type="checkbox"/> 21-26 <input type="checkbox"/> 27-35 <input type="checkbox"/> 36 or more	
Applicant Name _____ Number of drinks consumed per week: <input type="checkbox"/> 0-7 <input type="checkbox"/> 8-14 <input type="checkbox"/> 15-20 <input type="checkbox"/> 21-26 <input type="checkbox"/> 27-35 <input type="checkbox"/> 36 or more	
5. Has anyone applying for coverage in this Application <b>EVER</b> been convicted of a felony, or been on, or is currently on probation? If yes, identify the person and details in the Additional Information Section.	<input type="checkbox"/> Yes <input type="checkbox"/> No

**LIFESTYLE - ADDITIONAL INFORMATION**

If any **lifestyle** questions were answered with 'yes,' the following information must be completed. Please explain and provide **FULL DETAILS** for each 'yes' answer to any of the preceding **lifestyle** questions and **INDICATE TO WHICH APPLICANT THE INFORMATION APPLIES.** If additional space is needed, list on a separate sheet of paper and attach to this Application to include the signature and date signed by the Applicants.

Q #	Applicant Name (Last, First, MI)	Details of answer: Conditions, treatment, convictions, etc. (Indicate number of occurrences)	Start Date (mm/yyyy)	End Date (mm/yyyy)

Applicant Name: \_\_\_\_\_  
 CHC-GA-INDV-Application-0908

Broker: Bill Howell

Q #	Applicant Name (Last, First, MI)	Details of answer: Conditions, treatment, convictions, etc. (Indicate number of occurrences)	Start Date (mm/yyyy)	End Date (mm/yyyy)
Please check here if additional page is attached				<input type="checkbox"/>

**HEALTH QUESTIONS**

6. Has anyone applying for coverage in this Application <b>EVER</b> been treated for, or diagnosed with: cancer, including but not limited to melanoma, Hodgkin’s disease, malignant sarcomas, carcinomas, tumors or cysts; or heart attack, heart disease, stroke, aneurysm, multiple sclerosis, or hepatitis C? If cancer, provide location, type, stage, and treatment in the Additional Information Section.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Does anyone applying for coverage in this Application <b>HAVE OR EVER</b> had any implants (breast or penile), devices such as pacemakers, shunts, stents, valve replacements, monitoring devices or internal fixation devices (plates, pins or screws) or prosthetics?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Within the past <b>TEN (10) YEARS</b> , has anyone applying for coverage in this Application had any signs or experienced symptoms that caused them or would cause an ordinarily prudent person to seek advice, treatment or therapy, or consulted or sought medical treatment, been diagnosed, had medical treatment recommended, received medical treatment or therapy, been surgically treated, or been hospitalized for any of the following conditions:	
A) Cardiovascular disorders, <b>including but not limited to:</b> hypertension, or high blood pressure, chest pain, heart murmur, mitral valve prolapse, palpitations or heart rhythm disturbance or surgery?  If history of hypertension, high blood pressure or elevated blood pressure readings, provide three (3) blood pressure readings and dates, including the highest reading within the last <b>SIX (6) MONTHS</b> . These readings must have been taken by a physician.  Date _____ Reading _____      Date _____ Reading _____      Date _____ Reading _____ Highest reading in last SIX (6) MONTHS: Date _____ Reading _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
B) Blood disorders, <b>including but not limited to:</b> anemia, hemophilia, purpura, thrombocytopenia, leukemia, sickle cell anemia, abnormal white or red blood cells or abnormal bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C) Vein or artery disorders, <b>including but not limited to:</b> phlebitis, thrombosis, varicose veins or ulcers, peripheral vascular disease or clots and poor circulation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D) Connective tissue disorders, <b>including but not limited to:</b> systemic (SLE) or discoid lupus, scleroderma, rheumatoid arthritis, CREST or Sjogren’s syndromes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E) Cerebrovascular disorders, <b>including but not limited to:</b> stroke, transient ischemic attack (TIA), carotid bruits, or cerebral (brain) hemorrhage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F) Immune or lymph system disorders, <b>including but not limited to:</b> persistent lymph node enlargement, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV), persistent fever, persistent diarrhea, persistent fatigue, or weight loss of unknown cause?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G) Nervous system disorders, <b>including but not limited to:</b> migraines, dizziness, epilepsy, fainting, tremors, convulsions, seizures, paralysis, autism, Alzheimer’s, Parkinson’s, amyotrophic lateral sclerosis (ALS) or cerebral palsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
H) Respiratory system disorders, <b>including but not limited to:</b> asthma, sinusitis, allergic rhinitis, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), dyspnea, tuberculosis, sarcoidosis or sleep apnea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
I) Metabolic or endocrine disorders, <b>including but not limited to:</b> obesity, elevated lipids (cholesterol, triglycerides), diabetes or sugar intolerance; disorder of the thyroid, pituitary, adrenal, pancreas or other gland or goiter?	<input type="checkbox"/> Yes <input type="checkbox"/> No
J) Musculoskeletal disorders, <b>including but not limited to:</b> arthritis, fibromyalgia, gout, back, neck or spinal column disorders such as herniated disc(s); osteopenia/osteoporosis, ankylosing spondylitis, fractures, dislocations or disorders, polio/post-polio syndrome, muscular dystrophy, amputation, or persistent or recurring pain of the muscles, bones or joints or had spinal adjustments or manipulation therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
K) Urinary tract disorders, <b>including but not limited to:</b> kidney or bladder stones, cystitis or other urinary tract infections, urethral stricture or stenosis, kidney transplant or dialysis, renal failure or polycystic kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
L) Hernias, <b>including but not limited to:</b> inguinal, scrotal, hiatal (diaphragmatic) or umbilical?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Applicant Name: \_\_\_\_\_  
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M) Female reproductive system disorders, <b>including but not limited to:</b> infertility, irregular menstruation, uterine fibroids, uterine prolapse, endometriosis, abnormal PAP smears, caesarian section or other complications of pregnancy? Date / results of most recent PAP smear: Date (mm/yyyy): _____ Results: _____ Date / results of first prior PAP smear: Date (mm/yyyy): _____ Results: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
N) Ear, eye, nose, throat or skin disorders, <b>including but not limited to:</b> recurrent ear infections, Meniere's disease, deafness, blindness, cataracts, detached retina, glaucoma, optic atrophy, deviated nasal septum, nasal polyps, psoriasis, acne or skin tumors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
O) Breast disorders, <b>including but not limited to:</b> breast cysts or tumors, fibrocystic breast disease, gynecomastia, mastitis or abnormal mammograms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
P) Male reproductive disorders, <b>including but not limited to:</b> prostate disorder(s), elevated PSA testing, erectile dysfunction, infertility or male genital disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Q) Mental or nervous disorders, <b>including but not limited to:</b> attention deficit disorder, anxiety, depression, eating disorders, bipolar disorder, schizophrenia or psychotic disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
R) Intestinal or rectal disorders, <b>including but not limited to:</b> Crohn's disease, ulcerative colitis, intestinal polyps, hemorrhoids, irritable bowel syndrome (IBS), diverticulitis / diverticulosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
S) Sexually transmitted diseases, <b>including but not limited to:</b> gonorrhea, chlamydia, human papillomavirus (HPV), syphilis, genital warts or genital herpes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
T) Digestive system disorders, <b>including but not limited to:</b> gastroesophageal reflux disease (GERD), esophageal stricture, esophageal varices, cirrhosis or other liver disorder, spleen disorder, stomach or duodenal ulcer(s), gallbladder disease or gall stones?	<input type="checkbox"/> Yes <input type="checkbox"/> No
U) Abnormal diagnostic tests, <b>including but not limited to:</b> abnormal blood tests, abnormal MRI or CT scan, x-ray, bone density, abnormal electrocardiogram (EKG) or echocardiogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Within the past <b>FIVE (5) YEARS</b> , has any person applying for coverage in this Application:	
A) Consulted or been examined or treated by any physician, chiropractor, psychologist, or other health care practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B) Been to a clinic, hospital, emergency room, or other medical facility for treatment, confinement, or observation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C) Had or been advised to have a surgical procedure, tests or treatment that have not yet been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D) Had any disease, disorder, ailment, injury or condition not listed in this Application for which there have been, or are plans or intentions to seek advice, diagnosis, or treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PRESCRIPTION MEDICATIONS AND INJECTION THERAPY**

List all medications and injection therapy taken or prescribed within the last **TWELVE (12) MONTHS** for any Applicant listed on this Application. Please include any over-the-counter (OTC) medications taken on a regular basis. If additional space is needed, list on a separate sheet of paper and attach to this Application to include the signature and date signed by the Applicants.

Applicant Name (Last, First, MI)	Medication / Dosage / Frequency (e.g., Lopressor™ / 100mg / daily)	Reason Prescribed / Taken	Date Prescribed (mm/dd/yyyy)	Still taking?	Date discontinued (mm/dd/yyyy)	Name, Address and Phone Number of Prescribing Physician
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please check here if additional page is attached

Applicant Name: \_\_\_\_\_  
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Broker: Bill Howell

**HEALTH HISTORY - ADDITIONAL INFORMATION**

If any **health history** questions were answered with 'yes,' the following information must be completed. Please explain and provide **FULL DETAILS** for each 'yes' answer to of the preceding **health history** questions and **INDICATE TO WHICH APPLICANT THE INFORMATION APPLIES**. If additional space is needed, list on a separate sheet of paper and attach to this Application. Include the signature and date signed by the Applicants.

Q #	Applicant Name (Last, First, MI)	Conditions, treatment, operations (Indicate number of occurrences)	Date of onset (mm/yyyy)	Date of recovery (mm/yyyy)	Days in hospital	Last checkup for condition (mm/yyyy)	Results	Name, Address and Phone Number of Health Care Provider

Please check here if additional page is attached

**HEALTH CARE PROVIDERS SEEN IN THE PAST 5 YEARS NOT LISTED ABOVE**

Applicant Name (Last, First, MI)	Name, Address and Phone Number of Health Care Provider	Details of Last Visit		
		Date (MM/YYYY)	Reason for Visit	Result (Circle one. If abnormal, explain) Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal

Please check here if additional page is attached

Applicant Name: \_\_\_\_\_  
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Broker: Bill Howell

**CONDITIONS OF ENROLLMENT**

I represent that all information on this Application form is complete and accurate and true to the best of my knowledge. I understand that my answers to the questions on this form will be used as the basis to determine eligibility for coverage. I further understand that if any information is omitted or intentionally misrepresented, it could provide the basis to refuse, reform or rescind coverage and to adjust as applicable, or 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. I understand that if my health or any of the answers or statements provided herein change prior to notification of an offer of coverage, I must inform Coventry of such in writing. I understand that failure to do so may result in the denial, reformation or rescission of coverage.

I understand and acknowledge that the selling agent, if applicable to this Application for coverage, has no authority to promise coverage to Applicants herein or to modify CoventryOne underwriting policy or the terms of Coventry coverage.

**ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT STATEMENT OR REPRESENTATION OF ANY MATERIAL FACT OR THING IN THE FILING OF A CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE WILL BE GUILTY OF A FELONY AND WILL BE PUNISHED BY IMPRISONMENT, OR BY FINE, OR BOTH.**

THE EFFECTIVE DATE OF COVERAGE OF APPLICANTS LISTED HEREIN IS ASSIGNED BY COVENTRY AT ITS DISCRETION, SUBJECT TO MEDICAL UNDERWRITING; AND AN OFFER OF COVERAGE AND PREMIUM AMOUNT BEING PRESENTED AND ACCEPTED.

**DO NOT CANCEL EXISTING INSURANCE COVERAGE UNTIL NOTIFIED IN WRITING BY COVENTRY OF APPLICATION APPROVAL.**

**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. 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 instructions on how to obtain 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 at 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 and 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.

<hr/> <b>PRIMARY APPLICANT'S SIGNATURE</b>	<hr/> DATE	<hr/> <b>SPOUSE'S SIGNATURE</b> (If applying for coverage)	<hr/> DATE
<hr/> <b>DEPENDENT APPLICANT SIGNATURE*</b>	<hr/> DATE	<hr/> <b>DEPENDENT APPLICANT SIGNATURE*</b>	<hr/> DATE
<small>*Required if age 18 or older.</small>			
<small>If minor child-only application (under the age of 18), this section must be signed by the minor child (children's) parent or legal guardian identified in the Applicant and Dependent Information Section.</small>			
<hr/> <b>PARENT / LEGAL GUARDIAN SIGNATURE</b>	<hr/> PRINT NAME	<hr/> RELATIONSHIP TO APPLICANT	<hr/> DATE

**- Please keep a copy of the completed, signed application for your files. -**

**Applicant Name:** \_\_\_\_\_  
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**Broker:** Bill Howell

**PREMIUM PAYMENT**

Premiums due for coverage under a policy pursuant to the approval of this Application and acceptance of coverage will be paid from funds automatically deducted from either a checking or savings account, upon the Account Holder's authorization herein, subject to the Coventry approval of this Application and the acceptance of an offer coverage. To facilitate the premium withdrawal this section must be completed in its entirety. This payment information does not guarantee approval or coverage.

Premiums due for coverage may be facilitated by non-automated account deduction. When non-automated account deduction is selected, a check or money order for the initial premium amount due must accompany this Application, and thereafter upon receipt of monthly statement. A \$5.00 monthly administrative fee is assessed for this service. The Account Holder may opt to switch to premium payment by automatic withdrawal at anytime during the course of the policy period. Election to shift from automatic withdrawal to non-automated account deduction is permitted once per policy period, or upon renewal. To shift payment method, contact Coventry.

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 of Account Holder: \_\_\_\_\_

Relationship of Account Holder to the Primary Applicant:  Self  Spouse  Other \_\_\_\_\_

Permanent Address of Account Holder: \_\_\_\_\_  
\_\_\_\_\_

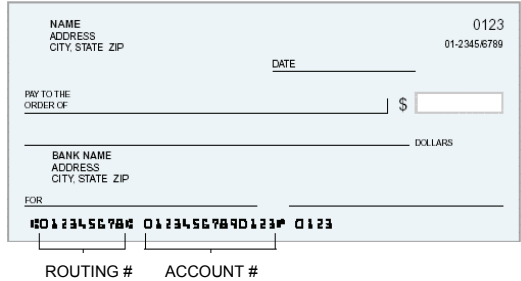
Applicable Premium amount is automatically withdrawn from the account provided herein on the 10<sup>th</sup> day of each current coverage month, or the next business day. The initial premium withdrawal may not occur until the 10<sup>th</sup> of the month following the first month of coverage and will account for the total amount owed from the original effective date. For example, if the first months' premium is calculated beginning on the 15<sup>th</sup> of the month but not withdrawn until the 2<sup>nd</sup> month of coverage, the amount due in the 2<sup>nd</sup> month will equal one and one half (1½) the total monthly premium amount. If the first months' premium is calculated beginning on the 1<sup>st</sup> of the month but not withdrawn until the 2<sup>nd</sup> month of coverage, the amount due in the 2<sup>nd</sup> month will be twice the total monthly premium amount.

If premium payment is returned unpaid, a Return Check Fee amount will be assessed in the amount of \$20.00. Account Holder hereby authorizes Coventry to collect the premium payment due on the 10<sup>th</sup> of the month, or next business day, including the Return Check Fee amount, via electronic funds transfer (EFT) or automatic withdrawal from the account identified and provided herein or then current.

By signing below, I authorize Coventry to initiate automatic withdrawal of applicable premium payments from the account listed above.

I, the Account Holder, acknowledge and understand that it is my responsibility to notify Coventry should the payment information provided herein change while a policy of coverage pursuant to this Application remains in force and effect.

Account Holder Signature: \_\_\_\_\_ Date: \_\_\_\_\_



- Please keep a copy of the completed, signed application for your files. -

**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 or its authorized representatives, 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 Coventry to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by Coventry for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for Coventry 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 Coventry 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 Coventry to use or disclose the information I provide in this Application (or that the Coventry 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 Coventry prior to the date such revocation is received by Coventry.

_____ <b>PRIMARY APPLICANT'S SIGNATURE</b>	_____ DATE	_____ <b>SPOUSE'S SIGNATURE</b> (If applying for coverage)	_____ DATE
_____ <b>DEPENDENT APPLICANT SIGNATURE*</b>	_____ DATE	_____ <b>DEPENDENT APPLICANT SIGNATURE*</b>	_____ DATE
*Required if age 18 or older.			
If minor child-only application (under the age of 18), this section must be signed by the minor child (children's) parent or legal guardian identified in the Applicant and Dependent Information Section.			
_____ <b>PARENT / LEGAL GUARDIAN SIGNATURE</b>	_____ <b>PRINT NAME</b>	_____ <b>RELATIONSHIP TO APPLICANT</b>	_____ DATE

**BROKER INFORMATION**

The following sections are to be completed by the broker.

Broker Name: <u>Bill Howell</u>	Broker ID #: <u>412134</u>	Broker Email Address: <u>bill@basichealthcare.com</u>
Broker Signature: _____	Agency Name: <u>Bill Howell</u>	Broker/Agency Phone: <u>(70) 938-9000</u>

**PRODUCER CERTIFICATION**

I am not aware of any other information which may have a bearing on the insurability of anyone to be covered and have not altered any responses recorded on this Application or any supplement to it. I have not advised the Applicant to withhold any information regarding the answers to the questions and have advised the Applicant to review the Application and the answers recorded to confirm completeness and accuracy. I further attest that my answers recorded in the preceding sections are correct, complete, and wholly true to the best of my knowledge and belief.

Producer Signature \_\_\_\_\_ Date \_\_\_\_\_

- Please keep a copy of the completed, signed application for your files. -

Applicant Name: \_\_\_\_\_  
CHC-GA-INDV-Application-0908

Broker: Bill Howell