COVENTRY
Health Care of Georgia, Inc.

Enrollment/Change Form

COVENTRY
Health and Life Insurance Company

A EMPLOYER INFORMATION

Group No.	Group Name	Effective Date/Change Date

B SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	MI	M/F	BIRTHDATE	HEIGHT/WEIGHT	SOCIAL SECURITY NO.	MARITAL STATUS Please check one: ☐ SINGLE ☐ MARRIED ☐ DIVORCED

ADDRESS	PCP ID# (IF APPLICABLE)

CITY	STATE	ZIP	COUNTY	HOME PHONE	WORK/DAY PHONE

C TYPE OF CHANGE

ENROLL

☐ Open Enrollment

☐ New Hire (date of hire) _____

☐ COBRA (date of eligibility) _____

☐ Add Dependent (reason for addition) _____

TERMINATE COVERAGE

☐ Cancel Coverage (reason) _____

☐ Last Date of Employment _____

☐ Delete Dependent (reason for deletion) _____

CHANGE

☐ Open Enrollment Benefit Plan Change (section D)

☐ Name Change (previous name) _____

☐ Address Change (new address listed above)

☐ Other _____

D BENEFIT PLAN SELECTION (NEW ENROLLMENT OR BENEFIT CHANGE ONLY)

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS:

Coventry Health Care of Georgia

☐ Premier ☐ Premier Plus ☐ Other

Coventry Health and Life Insurance Company

☐ Premier PPO ☐ Other

E FAMILY MEMBERS TO BE COVERED OR DELETED

ENROLL OR DELETE	FULL NAME (LAST, FIRST, MI)	SEX	RELEATIONSHIP	BIRTHDATE	STUDENT OR DISABLED	SOCIAL SECURITY	PCP ID (IF APPLICABLE)
☐ E ☐ D		☐ M ☐ F	SPOUSE			- -	
☐ E ☐ D		☐ M ☐ F			☐ Y ☐ N ☐ Y ☐ N	- -	
☐ E ☐ D		☐ M ☐ F			☐ Y ☐ N ☐ Y ☐ N	- -	
☐ E ☐ D		☐ M ☐ F			☐ Y ☐ N ☐ Y ☐ N	- -	
☐ E ☐ D		☐ M ☐ F			☐ Y ☐ N ☐ Y ☐ N	- -	

F OTHER INSURANCE

Do you or your dependents have other coverage? Yes ☐ No ☐ If Yes, complete the following:

List all covered family members with medical health insurance in addition to Coventry Health Care of Georgia or Coventry Health and Life Insurance Company (Coventry)

POLICY HOLDER	BIRTHDATE	EMPLOYER	INSURANCE COMPANY

LIST DEPENDENTS COVERED	EFFECTIVE DATE	CONTRACT NO//GROUP NO.

Do you or your covered dependents have Medicare Coverage? _____ Yes_____ No If Yes, please complete the following:

NAME	MEDICARE ID NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE

G EMPLOYEE SIGNATURE

I HAVE READ AND AGREE TO THE STATEMENTS ON THE REVERSE SIDE.

Employee Signature **Date**

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 1-800-395-2545.**

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.chcaa.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.