COVENTRY HEALTHAMERICA
An Aetna Company

Pennsylvania in-area PPO is underwritten by HealthAssurance Pennsylvania, Inc., d.b.a HealthAmerica ("HealthAmerica"). Out-of-area PPO products are underwritten by Coventry Health and Life Insurance Company, d.b.a HealthAmerica ("HealthAmerica"). HMO products are underwritten by HealthAmerica Pennsylvania, Inc. d.b.a. HealthAmerica HMO.

Employee Enrollment/Change Form

Important: Please print clearly in BLACK ink or type as instructed in each section. Initial and date corrections; correction fluid is not permitted. Read and sign the Acknowledgements Section.

Product Choice Choose one (1) product only.

☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ OTHER ☐ None/ Waive

Employer Information

Company Name:	Group Number:
Date Employed Full-Time: ____ / ____ / _____ (mm/dd/yyyy)	Effective Date of Coverage: ____ / ____ / _____ (mm/dd/yyyy)
Reason For Enrollment: ☐ New Group ☐ COBRA ☐ State Continuation ☐ New Hire ☐ Retired ☐ Qualifying Event ☐ Open Enrollment Date: ____ / ____ / _____ (mm/dd/yyyy)	Employee Status: ☐ Active Employee ☐ State Continuation ☐ COBRA ☐ Other _____

Reason For Change (Please check all that apply and include supporting documentation):
☐ Enroll Dependent ☐ Terminate Dependent ☐ Terminate Subscriber
☐ Name Change (previous name) ☐ Address/Phone ☐ PCP Change _____ (New PCP Name)

Termination Reason:
☐ Group Request ☐ Member Request ☐ Deceased

Effective Date of Change:
____ / ____ / _____
(mm/dd/yyyy)

Subscriber Information Please provide information on the Subscriber.

Last Name	First Name	MI	County

Home Address *(not P.O. Box)*	City	State	Zip	Phone Number(s): ☐ Home ( ) - ☐ Work ( ) - ☐ Mobile ( ) - ☐ If available, I would like to get information by Text.
Mailing Address *(If different from address above)*	City	State	Zip	

Marital Status ☐ Single/Widow ☐ Married ☐ Divorced	Job Description	Hours worked: _____/week

E-mail Address

Primary Language (*if other than English*): ☐ Spanish (Español) ☐ Navajo (Dine) ☐ Chinese (中文) ☐ Tagalog (Tagalog)

ELECTRONIC COMMUNICATIONS: I ACKNOWLEDGE AND UNDERSTAND THAT BENEFIT DOCUMENTS, LEGAL DOCUMENT, AND PROVIDER NETWORK INFORMATION FOR HEALTHAMERICA PLANS WILL BE MADE AVAILABLE TO ME IN ELECTRONIC FORMAT THROUGH THE HEALTHAMERICA WEBSITE AND MY ONLINE SERVICES AT WWW.HEALTHAMERICA.CVTY.COM. MY ENROLLMENT IN THE PLAN INCLUDES THIS ELECTRONIC ACCESS. TO RECEIVE PRINTED DOCUMENTS AT NO COST TO ME, I MUST CONTACT CUSTOMER SERVICE TOLL-FREE AT 1-800-788-8445 IN CENTRAL AND EASTERN PA OR 1-800-735-4404 IN WESTERN PA.

Subscriber and Dependent Information

General Information List all individuals applying for health coverage in this section. If you need more space, attach a separate sheet of paper with the details in the same format as the box below. Sign and date any attachments.

1 Subscriber				
Last Name	First Name	MI	Tobacco use in past 6 months?[1] ☐ Yes ☐ No	Primary Care Physician Name [2]
SSN	Birthdate (mm/dd/yyyy)	M/F		PCP ID# [2]

2 Spouse				
Last Name	First Name	MI	Tobacco use in past 6 months?[1] ☐ Yes ☐ No	Primary Care Physician Name [2]
SSN	Birthdate (mm/dd/yyyy)	M/F		PCP ID# [2]

3 Dependent Type ☐ Child ☐ Grandchild ☐ Domestic Partner				
Last Name	First Name	MI	Tobacco use in past 6 months?[1] ☐ Yes ☐ No	Primary Care Physician Name [2]
SSN	Birthdate (mm/dd/yyyy)	M/F		PCP ID# [2]

4 Dependent Type ☐ Child ☐ Grandchild ☐ Domestic Partner				
Last Name	First Name	MI	Tobacco use in past 6 months?[1] ☐ Yes ☐ No	Primary Care Physician Name [2]
SSN	Birthdate (mm/dd/yyyy)	M/F		PCP ID# [2]

5 Dependent Type ☐ Child ☐ Grandchild ☐ Domestic Partner				
Last Name	First Name	MI	Tobacco use in past 6 months?[1] ☐ Yes ☐ No	Primary Care Physician Name [2]
SSN	Birthdate (mm/dd/yyyy)	M/F		PCP ID# [2]

1 'Tobacco use' constitutes use of any tobacco products (excluding the religious or ceremonial use of tobacco) four or more times per week on average within no longer than the past 6 months.

2 'Primary Care Physician (PCP)' refers to the provider that you would see first for any medical problem. For Health Maintenance Organization (HMO) products, the PCP must be within our provider network. A list of participating providers can be found at the health plan's website www.healthamerica.cvty.com. Please note that choice of PCP is not guaranteed; however, should you be accepted for coverage, you can change your PCP at any time.

Existing / Prior Insurance Coverage

Does any individual applying for coverage currently have health or dental insurance coverage? ☐ Yes ☐ No

If you answered yes, please complete the following:

Insurance Company Name	Effective Date	Termination Date	Name of Persons Insured

Will the existing policy remain in effect? ☐ Yes ☐ No	Policy Type: ☐ Group ☐ Individual ☐ Medicare ☐ Pharmacy ☐ Medicaid ☐ Tricare ☐ Other _____

Medicare Information: ☐ Subscriber ☐ Dependent		
Effective Date Of: Part A ____ / ____ / ____ Part B ____ / ____ / ____ Part C ____ / ____ / ____	Last Name, First Name Medicare #	Reason for Medicare Eligibility: ☐ Over 65 ☐ ALS (Lou Gehrig's Disease) ☐ Disabled ☐ Kidney Disease (ESRD)

Medicare Information: ☐ Subscriber ☐ Dependent		
Effective Date Of: Part A ____ / ____ / ____ Part B ____ / ____ / ____ Part C ____ / ____ / ____	Last Name, First Name Medicare #	Reason for Medicare Eligibility: ☐ Over 65 ☐ ALS (Lou Gehrig's Disease) ☐ Disabled ☐ Kidney Disease (ESRD)

WAIVER My Employer has given me an opportunity to apply for group health coverage for myself and my dependents (if applicable)

If you are waiving medical coverage for yourself or your dependents (including your spouse) because of other medical coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after a marriage, birth, adoption or placement for adoption. If you are waiving medical coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period.

I have declined to apply for coverage for:	Reason for decline:
☐ Myself ☐ Spouse ☐ Dependents	☐ Other Health Insurance ☐ Spousal Coverage ☐ Other Reason (please explain)

Employee Signature (ONLY IF YOU ARE WAIVING COVERAGE)	Date

Acknowledgements

By signing this Enrollment/Change form, I, the Subscriber, including any undersigned Spouse and Dependents, agree to the following statements:

- I understand that the information that I provide on this Enrollment/Change Form will be used to determine eligibility for health insurance coverage for which I am applying. I attest that my responses are complete and accurate to the best of my knowledge.
- I understand that if any material information is omitted or misrepresented from any section of the Enrollment/Change Form, coverage may be refused, terminated, or rescinded, at HealthAmerica's sole discretion. HealthAmerica may rescind coverage only in cases of fraud or intentional misrepresentation of a material fact. In the event that coverage is rescinded, the policy will be voided back to the original effective date and all premium payments will be refunded. HealthAmerica shall not be financially liable for any health care services rendered prior to the rescission.
- I agree to notify HealthAmerica in writing if I or any Dependents applying for health insurance coverage has any changes to the answers or statements provided on this Enrollment/Change Form between the date this Enrollment/Change Form is signed and the effective date or approval date of coverage, whichever is later. My failure to provide HealthAmerica with this updated health information may result in a change of rate, denial or rescission of coverage.
- I understand that my enrollment and benefits are in accordance with those described in the applicable Evidence of Coverage, and Group Agreement or Group Policy. I authorize: 1) all health providers and insurers to furnish HealthAmerica, and 2) all health providers and HealthAmerica to furnish all insurers and health providers record concerning me or any member of my family for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative is entitled to receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that all the above information is correct. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through HealthAmerica. For purposes of collecting information for an insurance policy application, policy reinstatement, or a request for change in policy benefits, this authorization shall remain valid for twenty-four months from the date the authorization is signed. The insured has the right to revoke this authorization at any time. I represent on behalf of myself and any applicable dependents that to the best of my knowledge and belief all information submitted to HealthAmerica is complete and true, and I agree that this information shall be taken as the basis of the issuance of coverage for me and for each of the eligible dependents listed. I understand and agree that HealthAmerica will rely upon the information and answers I have provided as the basis for establishing group premium rates applicable to such policy.

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.

Employee's Signature	Date
Employer's Signature	Date