

Enrollment / Change Form 26 - 50 Eligible Employees



* Denotes required fields for enrollment. For items with ** please select a Reason for Enrollment OR a Reason for Change.

A EMPLOYER INFORMATION: To Be Completed By Employer
 New Group New Enrollment Change Waive (please complete section F)

Company Name: _____ *Group No.: _____

Date Employed Full Time: ____/____/____ *Effective Date of Coverage or Change: ____/____/____

<p>**REASON FOR ENROLLMENT</p> <p><input type="checkbox"/> New Group: <input type="checkbox"/> New Hire:</p> <p><input type="checkbox"/> COBRA: <input type="checkbox"/> Retired:</p> <p><input type="checkbox"/> Open Enrollment: <input type="checkbox"/> Qualifying Event (Reason): Date ____/____/____</p>	<p>**REASON FOR CHANGE: (Please check all that apply and include supporting documentation.)</p> <p><input type="checkbox"/> Enroll Dependent <input type="checkbox"/> Terminate Dependent</p> <p><input type="checkbox"/> Terminate Subscriber <input type="checkbox"/> Name Change (Previous Name)</p> <p><input type="checkbox"/> Address/Phone</p> <hr/> <p>Termination Reason:</p> <p><input type="checkbox"/> Group Request <input type="checkbox"/> Member Request <input type="checkbox"/> Deceased</p>
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EMPLOYEE STATUS:
 Active COBRA Salary Hourly Number of hours a week _____ Retired Other _____

Benefits Administrator Approval: _____ Date: _____

B SUBSCRIBER INFORMATION

Type of Coverage: Employee Employee/Spouse Employee/Children Employee/Spouse/Children

*Last Name: _____ *First Name: _____ MI: _____

*Gender: Male Female *Birthdate: ____/____/____ *Social Security Number: ____-____-____

*Address: _____
 *City: _____ *State: _____ *Zip Code: _____

Email Address: _____
 Height: ____ Weight: ____ Marital Status (please check one):
 Single/Widowed Married Divorced Separated

Work Phone: ____-____-____ Home Phone: ____-____-____

C FAMILY MEMBERS TO BE COVERED OR DELETED If address and phone numbers of covered dependents are different from that of policy holder, please attach that information on a separate sheet of paper.

Add Delete *Last Name: _____ *First Name: _____ MI: _____

*Gender: Male Female Birthdate: ____/____/____ Height: ____ Weight: ____ Student/Disabled: Student Disabled

Relationship: Spouse Child Other _____ Social Security Number: ____-____-____

Add Delete *Last Name: _____ *First Name: _____ MI: _____

*Gender: Male Female Birthdate: ____/____/____ Height: ____ Weight: ____ Student/Disabled: Student Disabled

Relationship: Spouse Child Other _____ Social Security Number: ____-____-____

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

I understand that if I decide to apply for health coverage for myself and any applicable dependents at a later date, neither my dependents nor I will be eligible for coverage until (1) my employer's next open enrollment period, or (2) there is a qualifying event as defined in the Group policy.

Employee Signature (only if you are waiving coverage)

Date:

G AGREEMENT AND AUTHORIZATION Please read the following carefully.

1. I apply for membership in Coventry Health and Life Insurance Company, (CHL) for myself and for any eligible dependents listed. I authorize my employer to make deductions, if any, toward the premium cost of CHL.
2. I and my eligible dependents shall abide by the provisions of coverage in the Group Enrollment Agreement, Certificate of Coverage and Benefit Riders under which we are enrolled.
3. By signing this form, I authorize my employer & any physician, hospital, medical group or other facility providing me care, treatment or consultation, to disclose to CHL, or receive from CHL, any medical or claim information pertaining to the persons identified in this enrollment form receiving coverage under this plan, as may be necessary to enable CHL to make coverage determinations, pay claims or otherwise administer plan programs, including without limitation, credentialing of physicians and as applicable, other providers all of which shall be conducted in accordance with state and federal confidentiality laws. CHL will not disclose any information pertaining to HIV/AIDS or chemical dependency/substance abuse except as specifically permitted by applicable law.
4. I understand and agree no benefits shall take effect until this application is approved by CHL.
5. I understand that my membership may be cancelled for one or both of the following reasons: (1) failure to pay the amount due under the Group Enrollment Agreement or Certificate of Coverage, for which I am legally responsible, or (2) fraud or material misrepresentation in enrollment or in the use of services of facilities.
6. I understand that it is my responsibility to report to CHL any change in the eligibility of myself or my dependents.

By signing this form I certify ALL information is true and accurate.

I HAVE READ AND AGREE TO THE STATEMENTS ABOVE. (Signature Required Below)

Applicant Signature

Date

Applicant Printed Name

GENERAL PROVISIONS

1. ENROLLMENT RIGHTS NOTICE (Waived Coverage) - I understand that if I and/or any of my dependents, if any, waive coverage at this time and desire to participate in the plan at a future date, coverage could be subject to treatment as a late enrollee at that time. I further understand that even if I decline enrollment for myself or my dependents, spouse included, because of other health coverage at this time, I will still have the right to enroll myself and/or my dependents in this plan, provided I request enrollment within thirty-one (31) days of the time that such coverage ends. I also understand that if a new dependent relationship is formed due to marriage, birth, adoption, placement for adoption, or court order, I may be able to enroll myself and/or my dependents provided I request enrollment within thirty-one (31) days of such marriage, birth, adoption, placement for adoption or court order.

2. RESOLUTION OF DISPUTES - Please refer to the Certificate of Coverage, which outlines in detail CHL's Member Grievance and Appeals Procedure.