

## ILLINOIS CoventryOne Enrollment Application / Change Form

**A INDIVIDUAL INFORMATION (To Be Completed By Applicant)**

Last Name		First Name		MI	M/F	Age	Birthdate / /	Social Security Number		Requested Effective Date: <input type="checkbox"/> Day of CoventryOne Approval OR <input type="checkbox"/> ___/___/___	
Address				Employer			Occupation/Title		Business Phone ( ) -		E-mail address
City		State	Zip Code	County			Home Phone ( ) -		Height (ft. in.)	Weight (lbs.)	Tobacco Use Yes/No

**Benefit Selection – Please circle the benefit plan for which you are requesting coverage:**

PPO 100/60 – 500	PPO 100/60 – 2000	PPO 80/50 – 500	PPO 80/50 – 2000	QHDHP PPO 100/60 – 1500	QHDHP PPO 100/60 – 5000
PPO 100/60 – 1000	PPO 100/60 – 3000	PPO 80/50 – 1000	PPO 80/50 – 3000	QHDHP PPO 100/60 – 2000	SJ PPO 100/60 – 1500
PPO 100/60 – 1500	PPO 100/60 – 5000	PPO 80/50 – 1500	PPO 80/50 – 5000	QHDHP PPO 100/60 – 3000	SJ PPO 100/60 – 2500

**B FAMILY MEMBERS TO BE COVERED OR DELETED**

Full Name (Last, First, MI)	Gender	Relationship	Age	Birthdate	Student or Disabled Dependent	SS Number	Height (ft.in.)	Weight (lbs.)	Tobacco Use Yes/No
	M / F	<b>SELF</b>		/ /	-----	- -			
	M / F	SPOUSE		/ /	-----	- -			
	M / F			/ /	S / D	- -			
	M / F			/ /	S / D	- -			
	M / F			/ /	S / D	- -			
	M / F			/ /	S / D	- -			

**Are you, or anyone else applying for coverage, required to provide health care coverage for a child pursuant to a Qualified Medical Child Support Order or other court order?**     No     Yes

If yes, please list the children.	Child's Name	Responsible Party
	1. _____	_____
	2. _____	_____
	3. _____	_____
	4. _____	_____

**C OTHER HEALTH INSURANCE** Do you have other health coverage?  No (Skip to section E)  Yes (Complete this Section)

Policyholder Name	Policyholder Birthdate / /	Name of Insurance Company	Contract # / Group #	Policy Eff Date / /	Policy Term Date / /
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**Anyone applying for coverage hereunder having other health coverage must cancel that other health coverage upon our acceptance of the application for CoventryOne. If the other health coverage is not cancelled, we will terminate CoventryOne coverage back to your original effective date.**

Is anyone applying for coverage hereunder covered by or eligible for coverage under Medicare?  No  Yes

**D 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 monthly 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 Saving Institution: \_\_\_\_\_

Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_  
*(A voided check or savings account deposit slip may be attached in support of content in this section)*

Address of Bank \_\_\_\_\_

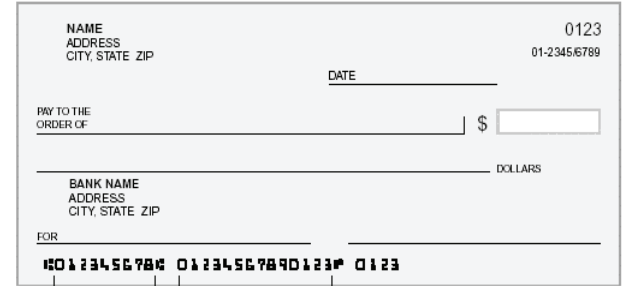
Name that appears on the Account \_\_\_\_\_

Address on the Account \_\_\_\_\_

Frequency of Transaction: Monthly Transaction Date: 10th Day of each Month

Your policy/coverage will be in effect when the premium rate has been presented and accepted, medical underwriting completed and approved, and premium payment received and applied to your account. By signing below, I authorize Coventry Health and Life Insurance Company 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.**

Accountholder Signature \_\_\_\_\_ Date \_\_\_\_\_



Routing Number      Account Number

## E HEALTH SAVINGS ACCOUNT (“HSA”) OPTION FOR QHDHP 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
- 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

## F HEALTH HISTORY

Please check Yes or No and provide details for all Yes answers below.

Within the past five (5) years have you or anyone else applying for coverage 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? Incomplete applications may be rejected or returned to you or anyone else applying for coverage for completion.

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"/>	11. Donor, recipient or a candidate for a transplant? When? _____	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"/>	12. Any amputations, prosthetic devices or implants?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Stomach or intestinal ulcer, colitis, Crohn’s disease, hernia, hepatitis, liver disease or disorder of the stomach, intestines, pancreas, rectum or gall bladder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	13. Any immune deficiency disorder, HIV, AIDS or AIDS-related complex?	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"/>	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"/>
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"/>	15. Have you been treated in the emergency room, been hospitalized or had any surgery in the past 5 years?	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"/>	16. Manic depression, bipolar, panic attacks, schizophrenia, obsessive-compulsive disorders (OCD), depression or behavioral disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Epilepsy, any seizure disorder, Alzheimer’s disease, fainting spells, migraines, frequent headaches, attention deficit disorders, paralysis, brain or neurological disorders? If epileptic, date of last seizure: _____	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"/>
8. Lupus, fibromyalgia, arthritis, fractures, back or spinal conditions, or disorder of the joints, muscles or bones?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	18. Thyroid, pituitary or adrenal gland disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Any bodily injury, concussion, burns, congenital problems or defects? Lyme disease or any chronic infections or infectious diseases?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	19. Sexually transmitted disease, abnormal pap smear or mammogram, breast disorder, disorder of male or female organs or menstrual dysfunction? Date of last menstrual cycle: _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. Diabetes or abnormal glucose test (high / low)? If diabetes, Type: _____ Any complications? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	20. Currently taking prescription medication(s) or receiving injection therapy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

21. Is any male or female applicant pregnant or an expectant parent? (this includes the process of adoption or surrogacy). Due date? _____ Whom? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	24. Anorexia, bulimia, gastric bypass or other eating disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
22. 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"/>	25. 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"/>
23. Sought or been advised to seek psychiatric, psychological or mental health treatment or counseling?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	26. Have you used tobacco products in the past 12 months? If Yes, what kind? _____ Frequency: _____ Whom? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
27. Any skin disorders such as psoriasis, acne, eczema, dermatitis, herpes, shingles or severe scars?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
28. Any pending or recommended surgery or procedure not yet performed, or have been advised to obtain equipment or services?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
29. List any disease, condition or impairment not mentioned above.					
30. Please describe any holistic, alternative, natural treatment or remedies in the past twelve (12) months.					
31. Applicant Name: _____  List last three blood pressure readings, if applicable: _____  List last three cholesterol readings, if applicable: _____  List last three blood sugar readings, if applicable: _____					
32. Please list any medication you or any one else applying for coverage are currently taking, or have taken in the past 12 months, including injection therapy.  Applicant Name: _____					
Name of Medication		Dosage		Prescribing Physician	
33. Name of applicant's current physician		Address		Phone #	
34. Name of dependent's current physician		Address		Phone #	
				Date and reason last consulted?	
				Date and reason last consulted?	
35. Have you or any member of your family previously been insured by a Coventry Health Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes    Whom: _____					

If you answered "Yes" to any of the previous medical questions, you and anyone else applying for coverage must complete the requested information about those conditions. Please explain and provide FULL DETAILS for each "Yes" answer to any condition(s) checked in the preceding boxes. Please give details on the last doctor visit and/or physical examination regardless of date or reason. Insert additional sheets if necessary.

Name of Applicant: \_\_\_\_\_

Question #	Condition or Diagnosis	Date of Onset/Treatment (Month/Year)	Date Ended	Still Under Treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes
Treatment Rendered		Medication (if taken)/ Date Prescribed/ Dosage		
Name of Hospital, Clinic or person providing care		Address		Phone #

Question #	Condition or Diagnosis	Date of Onset/Treatment (Month/Year)	Date Ended	Still Under Treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes
Treatment Rendered		Medication (if taken)/ Date Prescribed/ Dosage		
Name of Hospital, Clinic or person providing care		Address		Phone #

Question #	Condition or Diagnosis	Date of Onset/Treatment (Month/Year)	Date Ended	Still Under Treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes
Treatment Rendered		Medication (if taken)/ Date Prescribed/ Dosage		
Name of Hospital, Clinic or person providing care		Address		Phone #

Question #	Condition or Diagnosis	Date of Onset/Treatment (Month/Year)	Date Ended	Still Under Treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes
Treatment Rendered		Medication (if taken)/ Date Prescribed/ Dosage		
Name of Hospital, Clinic or person providing care		Address		Phone #

**G CONDITIONS OF ENROLLMENT**

I agree to enroll and to consent that Coventry Health and Life Insurance Company or its authorized representatives (collectively referred to as "Health Plan") may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to me or anyone applying for coverage for purposes of administering my health insurance benefit, including for treatment, payment or health care operations, as those terms are explained in detail in Health Plan's Notice of Privacy Practices and to the extent permitted by law.

I also agree that, to the extent permitted by law, health care providers, insurers, claims administrators, employers and others may disclose my personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, autoimmune deficiency syndrome (AIDS), AIDS related complex, human immunodeficiency virus (HIV) or genetic conditions to Health Plan for Health Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law.

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 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.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false, incomplete or misleading information in an application for insurance for the purposes of defrauding the company may be guilty of a crime and may be subject to denial of coverage, fines and confinement in prison.**

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

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

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_ Relationship \_\_\_\_\_  
If signed by someone other than the applicant.

Applicant Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Dependent Age 18 or Older

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Dependent Age 18 or Older

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Dependent Age 18 or Older

**H APPLICATION COMPLETION**

If you received assistance completing this application, please list the person or insurance producer who did so.

Name of Broker Steven J. Lang Broker ID Number 12535

Signature of Broker \_\_\_\_\_ Name of Agency Lang Insurance Service