HEALTHAMERICA
A Coventry Health Care Plan

New Business Small Group
Statement of Health/Employee Application

COVENTRY
Health and Life Insurance Company

Pennsylvania in-area PPO and CCPPO (POS) products are underwritten by HealthAssurance Pennsylvania, Inc. (d.b.a. HealthAmerica). All out-of-area PPO products and Ohio in-area PPO products are underwritten by Coventry Health and Life Insurance Company (d.b.a. HealthAmerica). HMO products are underwritten by HealthAmerica Pennsylvania, Inc.

A EMPLOYER INFORMATION (to be completed by employer)

Group Name

B SUBSCRIBER INFORMATION (to be completed by employee)

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS:

☐ PPO ____________ ☐ OA PPO ____________ ☐ Other ____________ ☐ None / Waive (Go to Section E)

Type of coverage: ☐ Employee ☐ Employee/Spouse ☐ Employee/Child/Children ☐ Family

EMPLOYEE STATUS
Please check one:
❏ Active ❏ COBRA
❏ Retired ❏ Salary ❏ Hourly

Date employed full time: ____________

No. of hours per week ____________

LAST NAME	FIRST NAME	MI	M/F	BIRTHDATE	HEIGHT	WEIGHT	SOCIAL SECURITY NO.

ADDRESS

CITY		STATE	ZIP	WORK PHONE	HOME PHONE

MARITAL STATUS
Please check one:
❏ Single/ Widowed
❏ Married
❏ Divorced

C FAMILY MEMBERS TO BE COVERED

FULL NAME (Last, First, MI)	HEIGHT	WEIGHT	SEX	RELATIONSHIP	BIRTHDATE	OUT OF AREA STUDENT	SOCIAL SECURITY #
			M F	SPOUSE	/ /		- -
			M F		/ /	Y N	- -
			M F		/ /	Y N	- -
			M F		/ /	Y N	- -
			M F		/ /	Y N	- -
			M F		/ /	Y N	- -

D OTHER INSURANCE

WHEN coverage with HealthAmerica **BEGINS**, will you or any of your dependents have any other medical insurance coverage? ❏ Yes ❏ 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 ____________

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

I have declined to apply for coverage for: ❏ myself ❏ spouse ❏ dependents Reason for decline: ❏ Spousal coverage - Spouse's Employer______________________

❏ Medicare/Medicaid ❏ Other reason (please explain) ______________________

Warning: Employees who decline medical coverage for themselves and/or dependents during the initial enrollment period then request coverage after 31 days will be considered late enrollees. Coverage for late enrollees is effective at the next open enrollment period. However, eligible employees will not be considered late enrollees for employee and/or dependent coverage (and coverage will not be deferred) if: (a) late enrollment is made under one of the circumstances described below; and (b) any required information or proof is furnished.

Late Enrollee Exceptions:

1. Termination of other health coverage; 2. Court order; 3. Election of different plan during open enrollment period: The employer offers multiple health plans, and request for enrollment under this plan is made during the open enrollment period established by for plan election; 4. Marriage; 5. Birth; 6. Adoption or placement for adoption.

I hereby acknowledge the above warning of the consequences of declining medical coverage at my initial enrollment. The information given on this waiver is correctly recorded, complete and true.

X **Employee Signature (ONLY IF YOU ARE WAIVING COVERAGE)** Date:

F HEALTH INFORMATION (Please answer completely. Incomplete answers could delay the decision on your request for coverage.)

Include information only for those applying for coverage on this policy. Please CHECK all applicable Yes/No responses, CIRCLE past/current condition(s), and provide corresponding details in the appropriate section. Conditions include, but are not limited to, the following:

	YES	NO		YES	NO
1. Cancer, tumor, or cyst			14. Arthritis, joint pain, lupus, fibromyalgia, fractures, or limb loss, vasculitis, or peripheral vascular disease		
2. Epilepsy, stroke, or paralysis			15. Hepatitis Type (Please circle): A, B, C, D or autoimmune hepatitis **OR** any other liver disorder/disease		
3. Head or spinal injuries, muscular dystrophy, cerebral palsy, or multiple sclerosis			16. Any drug or alcohol problems (Please give full details below to include any treatment or rehab.)		
4. Neck or back pain, disorders of the spine, or disk herniation/bulge			17. Any organ transplant (planned, recommended, or already performed)		
5. Any blood disorder such as, anemia, sickle cell, or hemophilia			18. Is any female to be covered currently pregnant? Due date ______ (Month/Day/Year)		
6. Bladder, kidney (kidney failure or dialysis), prostate, testicular, uterine, or breast conditions			19. Cigarette or tobacco use? If YES, type of product ______ and how much per day? ______		
7. Ulcerative colitis, Crohn's, diverticulitis, stomach ulcers, acid reflux, hernia, gallbladder, or rectal disorders			20. Any hospitalizations in the last 5 years (Please give full details below.)		
8. Emphysema, COPD, cystic fibrosis, or any other lung/respiratory disorder			21. Any future surgeries discussed, planned, or recommended (Please give full details below.)		
9. Diabetes Type I or II (Please give full details below.)			22. Currently taking any prescription medications? (Please give full details below.)		
10. Heart disease, irregular heartbeat, heart murmur, regurgitation, chest pain, congestive heart failure, or heart valve conditions			23. **Are there any other medical conditions not listed above** (Please give full details below.)		
11. Diagnosis of AIDS or AIDS-related condition; Positive result, other than a false positive on HIV test					
12. Thyroid, pituitary, pancreas or glandular disorders or disorders requiring growth hormones					
13. Sleep apnea or diseases of the throat, ears, nose, sinuses, or eyes (except glasses)					

Please give full details for all "Yes" questions above. ADDITIONAL PAGES MAY BE USED BUT MUST BE SIGNED AND DATED.

Question Number	Person's Name	Condition (include start date of condition)	Types of Treatment (month / year)	Medications (oral, injectable, infusion, or inhaled)	Is ongoing treatment needed? If yes, please explain:

G CONDITIONS OF ENROLLMENT

I AGREE: All information on this form and the attached health questionnaire is correct and true. I understand that it is the basis on which premiums may be determined under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment at least 25 hours a week. Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded. **I ACKNOWLEDGE THAT I** am applying for Preferred Provider Organization (PPO) coverage: I understand that if I or one of my dependents receive medically necessary covered services from a nonparticipating provider, HealthAmerica will cover only the lower level benefits set forth in the applicable certificate of insurance and I will be responsible for payment of any amount not covered by HealthAmerica. **AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION.** I authorize any insurance company, physician, hospital, clinic, health care provider or other organization, institution or person having records or knowledge of anyone listed on this application to give HealthAmerica or their designated agent any and all records pertaining to any medical history, services or treatment provided to anyone on this application for purposes of review, investigation or evaluation of coverage. This authorization and any copy thereof is valid for 30 months from the date signed. I, the applicant, acknowledge that I have read and understand the application in its entirety.

OHIO: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PENNSYLVANIA: 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 purposes 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.

I HAVE READ AND AGREE TO THE CONDITIONS OF ENROLLMENT (Signature Required Below)

Employee Signature	Employee Printed Name	Date