WELLPATH
A Coventry Health Care Plan

Enrollment / Change Form
26+ Employees

COVENTRY
Health and Life Insurance Company

* 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

Company Name: *Group No.:

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

Pre-existing conditions exclusion period is 12 months unless you provide proof of coverage (Certificate of Creditable Coverage) from your prior plan(s).

**REASON FOR ENROLLMENT:

☐ New Group ☐ New Hire
☐ COBRA ☐ Retired
☐ Open Enrollment ☐ Qualifying Event (Reason)
Date _____/_____/_____

**REASON FOR CHANGE:
(Please check all that apply and include supporting documentation.)

☐ Enroll Dependent ☐ Terminate Dependent
☐ Terminate Subscriber ☐ Name Change (Previous Name)
☐ Address/Phone _____

Termination Reason:
☐ Group Request ☐ Member Request ☐ Deceased

EMPLOYEE STATUS:
☐ Active ☐ COBRA ☐ Salary ☐ Hourly Number of hours a week _____ ☐ Other _____

B SUBSCRIBER INFORMATION

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS: ☐ **None / Waive (please complete section E and F)**

☐ WellPath Select, Inc. POS ____ ☐ Coventry Health and Life Insurance PPO ____ ☐ Other _____ ☐ WellPath Select, Inc. HMO ____

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

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 ***Relationship** ☐ Spouse ☐ Child ☐ Other **Disabled** ☐ Disabled ***Birthdate** / / **Social Security Number** - -

☐ Add ☐ Delete ***Last Name** ***First Name** **MI**

***Gender /** ☐ Male ☐ Female ***Relationship** ☐ Spouse ☐ Child ☐ Other **Disabled** ☐ Disabled ***Birthdate** / / **Social Security Number** - -

Applicant Name: _____

Add / Delete *Last Name *First Name MI

*Gender / Male / Female *Relationship / Spouse / Child / Other Disabled / Disabled *Birthdate Social Security Number

Add / Delete *Last Name *First Name MI

*Gender / Male / Female *Relationship / Spouse / Child / Other Disabled / Disabled *Birthdate Social Security Number

D PRIOR HEALTH INSURANCE INFORMATION AND OTHER MEDICAL AND/OR PHARMACY COVERAGE INFORMATION

D1 PRIOR HEALTH INSURANCE

☛ This section **MUST** be completed to receive credit for prior coverage and **REDUCE** or **ELIMINATE** any applicable waiting period.

Have you had any health insurance within the last sixty-three (63) days?

☐ YES ☐ NO **If YES, complete below and provide certificate of coverage:**

Name, Address and Phone Number of Health Insurance Company

Policy Number | Policyholder Name | Policyholder Date of Birth (mmddyy)

Effective Date (mmddyy) | Termination Date or Expected Termination Date (mmddyy) | ← **If other coverage will remain in effect, write N/A in term box, and complete section below.**

Family Members Covered **List Names and Relationships:**

Have you or any family dependents been a previous WellPath Select, Inc./Coventry Health and Life Insurance Company (WP/CHL)Plan member? ☐ YES ☐ NO

If YES, then dates and ID numbers

NOTICE ABOUT YOUR PRE-EXISTING CONDITION LIMITATIONS

This plan imposes a pre-existing condition exclusion for all employees and dependents whether they are timely or late enrollees. This means that if you have a medical condition before coming to our plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis care or treatment was recommended or received within a six-month period. Generally, this six-month period ends on the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to children under 19 years old, to pregnancy, nor to a child who is enrolled in the plan within 31 days of birth, adoption or placement for adoption or foster care. Eligible children (newborns, adoptive children, foster children and those added as a result of a court order) are not subject to this exclusion period when enrolled more than 31 days after one of the events listed above if your coverage type or the premiums owed are not affected by adding the child. When applicable, this exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage."

Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12 month exclusion period by your creditable coverage, you should give WellPath Select, Inc./Coventry Health and Life Insurance Company (WP/CHL) a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, WellPath Select, Inc./Coventry Health and Life Insurance Company (WP/CHL) will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact WellPath Select, Inc./Coventry Health and Life Insurance Company (WP/CHL) if you need help demonstrating creditable coverage. Throughout this notice, all references to "you" are meant to refer to both the employee and their dependents.

D2 When coverage with WellPath begins, will you or any of your family members have any other medical insurance coverage? ☐ Yes ☐ No
If you answered yes, please complete below.

COVERAGE TYPE: ☐ Group Policy ☐ Individual Policy ☐ Medicare ☐ Pharmacy ☐ Medicaid ☐ Tricare ☐ Other _____

Other Insurance Company Name | Policy Holder Name | Covered Dependents

Relationship: ☐ Spouse ☐ Child ☐ Other_____ Gender: ☐ Male ☐ Female Birthdate Effective Date of Other Insurance

Other Insurance Company Name | Policy Holder Name | Covered Dependents

Relationship: ☐ Spouse ☐ Child ☐ Other_____ Gender: ☐ Male ☐ Female Birthdate Effective Date of Other Insurance

Applicant Name: _____

Medicare Information

☐ **Subscriber or** ☐ **Dependent**

Effective Date Of:

Part A / /

Part B / /

Part D / /

Dependent's Last Name

Dependent's First Name MI

Medicare #

Reason for Medicare Eligibility

☐ Over 65
☐ Disabled
☐ Kidney Disease (ESRD)
☐ ALS (Lou Gehrig's Disease)

☐ **Subscriber or** ☐ **Dependent**

Effective Date Of:

Part A / /

Part B / /

Part D / /

Dependent's Last Name

Dependent's First Name MI

Medicare #

Reason for Medicare Eligibility

☐ Over 65
☐ Disabled
☐ Kidney Disease (ESRD)
☐ ALS (Lou Gehrig's Disease)

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: ☐ Other health insurance ☐ Spousal coverage ☐ Other reason (please explain)

_____

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 EOC/COI.

_____ _____

Employee Signature (only if you are waiving coverage) Date:

F CONDITIONS OF ENROLLMENT Please read the following carefully.

I hereby apply for membership or request a change in membership in this WellPath Select, Inc./Coventry Health and Life Insurance Company (WP/CHL) Plan. I understand that my enrollment and benefits are in accordance with those described in the applicable Evidence/Certificate of Coverage or Certificate of Insurance, and Group Contract or Group Policy. I authorize 1) all health providers and insurers to furnish WP/CHL, and 2) all health providers and WP/CHL to furnish all insurers and health providers records 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 WP/CHL. 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 thirty months from the date the authorization is signed. It is further understood that WP/CHL reserves the right to re-rate coverage if any supplied information is materially inaccurate or incomplete, or rescind coverage in the event of fraud or intentional material misrepresentation.

AGREEMENT AND AUTHORIZATION

By signing this form, I agree on behalf of myself and those family members enrolled in this WP/CHL Plan (Dependents) for whom I have authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as Enrolled Family) that WP/CHL may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering my health insurance benefit including treatment, payment, or health care operations, as those terms are explained in detail in WP/CHL's Notice of Privacy Practices and to the extent permitted by law. My Enrolled Family's consent includes agreement for the use or disclosure of health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV). By signing this form, I also agree on behalf of myself and my Dependents that, to the extent permitted by law, health care providers, insurers, claims administrators, employers, and others may disclose my Enrolled Family's 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, AIDS, ARC, or HIV to WP/CHL for WP/CHL's administration of health insurance benefits including treatment, payment, or health care operations purposes and other purposes permitted by law.

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

_____ _____

Applicant Signature **Date**

_____

Applicant Printed Name