WELLPATH
A Coventry Health Care Plan

Enrollment/Change Form
2-99 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 Employment ☐ 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:**

☐ 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 F and G)

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

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

E-mail 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/*Relationship ☐ Male ☐ Female ☐ Spouse ☐ Child ☐ Other_____

Disabled ☐ Disabled

*Birthdate / / *Social Security Number / /

*Height *Weight

☐ Add ☐ Delete *Last Name *First Name MI

*Gender/*Relationship ☐ Male ☐ Female ☐ Spouse ☐ Child ☐ Other_____

Disabled ☐ Disabled

*Birthdate / / *Social Security Number / /

*Height *Weight

Applicant Name: _____

Add / Delete *Last Name *First Name MI

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

*Height *Weight

Add / Delete *Last Name *First Name MI

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

*Height *Weight

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 (mm/dd/yyyy)

Effective Date (mm/dd/yyyy) | Termination Date or Expected Termination Date (mm/dd/yyyy) | ← 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. When applicable, the exclusion extends for not more than twelve months without medical care, treatment, or supplies ending after the effective date of coverage or twelve months after the enrollment date, whichever occurs first, or eighteen months after the enrollment date in the case of a late enrollee. 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: _____

E HEALTH INFORMATION

(Please answer each question fully and accurately. Incomplete answers could delay the processing of your requested coverage.)

In completing and answering questions in this Application, you do not need to include any Applicant's or any Applicant's family member's genetic information (including genetic testing, genetic services, genetic counseling or genetic education). You also do not need to include the medical history of any Applicant's family member, unless the family member is also applying for coverage under this Application. It is further understood that WP/CHL reserves the right to re-rate coverage if any supplied information is materially inaccurate or incomplete. Coverage may be rescinded in the event of fraud or intentional material misrepresentation.

Please provide the health history of you and your family members who will be covered on this application. For all "yes" answers, please CIRCLE the condition and provide details in the appropriate section below. Conditions include but are not limited to the following:

1. Cancer, tumor or cyst	☐ YES	☐ NO
2. Epilepsy, stroke or paralysis	☐ YES	☐ NO
3. Head or spinal injuries, Muscular Dystrophy, Cerebral Palsy, or Multiple Sclerosis	☐ YES	☐ NO
4. Neck or back pain, disorders of the spine, or disk herniation/bulge	☐ YES	☐ NO
5. Any blood disorder (such as: anemia, sickle cell, or hemophilia)	☐ YES	☐ NO
6. Bladder, kidney, (kidney failure or dialysis), prostate, testicular, uterine, or breast conditions	☐ YES	☐ NO
7. Vascular (blood vessel) disease	☐ YES	☐ NO
8. Ulcerative colitis, Crohn's, diverticulitis, stomach ulcers, acid reflux, hernia, gallbladder, or rectal disorders	☐ YES	☐ NO
9. Asthma, allergies, or hay fever	☐ YES	☐ NO
10. Emphysema, Chronic Obstructive Pulmonary Disease, Cystic Fibrosis, or any other lung/respiratory disorder	☐ YES	☐ NO
11. Diabetes? Type I or II (Please give full details below)	☐ YES	☐ NO
12. High Blood Pressure	☐ YES	☐ NO
13. Heart disease, irregular heartbeat, heart murmur, chest pain, or heart valve conditions	☐ YES	☐ NO
14. Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)	☐ YES	☐ NO
15. Cigarette or tobacco use -- If YES, type of product and how much per day _____	☐ YES	☐ NO
16. Thyroid, pituitary, pancreas, glandular, or disorder requiring growth hormones	☐ YES	☐ NO
17. Mental or nervous problems	☐ YES	☐ NO
18. Diseases of the eyes, ears, nose, sinuses, or throat (except glasses)	☐ YES	☐ NO
19. Arthritis, joint pain, lupus, fibromyalgia, fractures, or limb loss	☐ YES	☐ NO
20. Hepatitis Type: A, B, C, D (Please circle) **OR** any other liver disorder/disease	☐ YES	☐ NO
21. Any drug or alcohol problems	☐ YES	☐ NO
22. Treatment or rehab for drug or alcohol problems When _____ (Month/Year)	☐ YES	☐ NO
23. Any organ transplant (planned, recommended, or already performed)	☐ YES	☐ NO
24. Is anyone to be covered currently pregnant Due date _____ (Month/Day/Year)	☐ YES	☐ NO
25. Any hospitalizations in the last 5 years (Please give full details below)	☐ YES	☐ NO
26. Any future surgeries discussed, planned, or recommended (Please give full details below)	☐ YES	☐ NO
27. Currently taking any prescription medications (Please give full details below)	☐ YES	☐ NO
28. Are there any other medical conditions not listed above (Please give full details below)	☐ YES	☐ NO

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	Treatment (Month/Year)	Medication (oral, injectable, infusion or inhaled)	Is further treatment needed? If yes, please explain:

Applicant Name: _____

Medicare Information

☐ **Subscriber or** ☐ **Dependent**

Effective Date of:

Part A ☐☐/☐☐/☐☐☐☐

Part B ☐☐/☐☐/☐☐☐☐

Part C ☐☐/☐☐/☐☐☐☐

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 C ☐☐/☐☐/☐☐☐☐

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)

F 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**

G 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 herby affirm 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, subject to the incontestability provision.

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