Coventry Health Care of Delaware, Inc.
2751 Centerville Road, Suite 400
Wilmington, DE 19808

[ ] **NEW** [ ] **RENEWAL** **[ ] OPEN ACCESS**

HMO GROUP #: ______________________________
POS GROUP #: ______________________________

SMALL GROUP APPLICATION FOR STANDARD PACKAGE COST SHARING (Maryland)

GROUP INFORMATION

Company Name:	____________________	Coverage Effective Date:	____________________
Street Address:	____________________	Anniversary Date:	____________________
City, State, Zip:	____________________	Open Enrollment:	____________________
County:	____________________	Contact Title:	____________________
Group Contact Name:	____________________	Contact Fax:	____________________
Contact Telephone:	____________________	Billing Contact:	____________________
Billing Address:	____________________	Nature of Business:	____________________
City, State, Zip:	____________________	SIC Code	____________________
Previous Carrier:	____________________		

COVERAGE FOR OTHER CLASSES OF EMPLOYEES:

[ ] I hereby elect to offer all Part-Time Employees coverage under the Standard Package Cost Sharing Plan. "Part-Time Employee" means an employee who has a normal work week of at least seventeen and one-half (17 ½) hours a week, but less than thirty (30) hours a week, and has been continuously employed for at least four (4) consecutive months.

[ ] I hereby elect to offer all Other Employees Coverage under the Standard Package Cost Sharing Plan. "Other Employee" means an employee who works for a Small Employer on a full-time basis with a normal work week of thirty (30) or more hours, and is covered under another public or private plan of health insurance or other health benefit arrangement. Other Employee does not include an individual who works on a temporary or substitute basis or for fewer than thirty (30) hours in a work week.

[ ] I do not wish to offer coverage to Part-Time Employees or Other Employees.

ELIGIBILITY WAITING PERIOD:

[ ] First of Month following __________ days. [ ]__________ days following Date of Hire.

[ ] Other:____

TOTAL # OF ELIGIBLE EMPLOYEES:______________________ Participation Requirement: 75% of Eligible Employees

TOTAL # OF WAIVERS: ______________________

TOTAL # OF APPLICATIONS:______________________________ Average Age of Applicants:______________________

TERMINATION: The date of termination of coverage shall be

[ ] ____________ the date of termination of employment.

[ ] ____________ the last day of the month in which termination of employment occurs.

NOTE: The State of Maryland requires that an employer, labor union, association, or other entity to which a group contract has been issued to continue to pay the premium for an employee, member, or dependent under the contract until notice of termination of coverage has been received by the HMO.

COMPANY NAME: ______________________________________

BENEFITS:

	[ ] HMO Standard Plan 2004 ($30/40/250/100)	
[ ] Diamond Plan 1 ($20/30/250/100)	[ ] Diamond Plan 3 ($10/20/0/100)	[ ] Diamond Plan 5 ($10/20/250/75)
[ ] Diamond Plan 2 ($10/20/250/100)	[ ] Diamond Plan 4 ($10/20/100/100)	[ ] Diamond Plan 6 ($10/20/0/50)

Open Access with Out-Of-Network Benefits:

[ ] Diamond Plus 1 ($30/40/250/100)	[ ] Diamond Plus 3 ($10/20/250/100)	[ ] Diamond Plus 5 ($10/20/100/100)
[ ] Diamond Plus 2 ($20/30/250/100)	[ ] Diamond Plus 4 ($10/20/0/100)	[ ] Diamond Plus 6 ($10/20/250/75)

Prescription Rider: ____________________

[ ] $10/20/30 $0 Deductible	[ ] $0/25/50 $100 Deductible	[ ] $15/25/50 $0 Deductible
[ ] $15/20/30 $150 Deductible	[ ] $0/25/50 $250 Deductible	[ ] $15/25/50 $100 Deductible

DUAL OFFERING: [ ] No [ ] Yes

OPTIONAL BENEFITS: [ ] Vision [ ] Other ______________________________

MONTHLY RATES:

HMO Rates:
Emp $________ 2 Party $________ Emp+Spouse $________ Emp+Child(ren) $________ Family $________

POS Rates:
Emp $________ 2 Party $________ Emp+Spouse $________ Emp+Child(ren) $________ Family $________

MEDICARE WRAP RATES:
Emp $________ 2 Party $________ Emp+Spouse $________ Emp+Child(ren) $________ Family $________

POINT-OF-SERVICE OPTION: Under Maryland law, your employees may purchase a Point-of-Service option for health care services as an additional benefit. This Point-of-Service option allows your employees to obtain services from providers outside the HMO network under certain circumstances (described in the attached benefit description). You have the choice to pay this Point-of-Service option, pay a percentage of the cost of this option, or require your employees to pay for the entire cost of this option. Please indicate the employees who have chosen this Point-of-Service option by attaching their individual applications to this Application.

You have read and understand this disclosure statement and attachments and have provided notice of the availability of these additional benefits to your eligible employees.

APPLICATION: On behalf of the above named group, you hereby make application for a Group Master Contract to be issued by Coventry Health Care of Delaware, Inc. for the above listed benefits and the monthly premium rates shown. You understand that this application, if accepted by Coventry Health Care of Delaware, Inc., will form part of the Group Master Contract and is binding on both parties. On behalf of the above named group, you further agree that, by signing this Application the above named group will be bound by the terms and conditions contained herein as well as those in the Group Master Contract. You are authorized to commit to this contract arrangement on behalf of the above named company. If any required Premium payments are not received by Us by the end of the grace period, Covered Services for all enrolled Members shall be terminated on the last day of the grace period. **If you have any questions concerning the benefits and services that are provided or excluded under this agreement, please contact the Health Plan before signing this application.**

______________________________________ ______________________________________
Signature Date Please print or type name and title

______________________________________ ______________________________________
ACCEPTED: Coventry Health Care of Delaware, Inc. Date

BROKER INFORMATION (Please complete exactly as licensed)

Administrator Name (if applicable) ______________________________

Selling Agent or Broker: ______________________________ Agency Name: ____________________

Commissions Payable to: ______________________________ Tax ID or SS#: ____________________

Address: ______________________________ Telephone: ____________________

City, State, Zip: ______________________________ Fax Number: ____________________