COVENTRY Health Care

Coventry Health and Life
2751 Centerville Road, Suite 400, Wilmington, DE 19808
(800) 833-7423

Benefit Plan:
(Check One) ( ) Conversion _____ Date
( ) State Continuation Coverage _____ Date
( ) COBRA _____ Date

Group Enrollment Form

1. Please print or type all necessary information. DO NOT WRITE IN SHADED AREAS.
2. Complete all items requested.
3. NEW MEMBERS: Complete all items in Sections B, C and D.
4. CURRENT MEMBERS: Check all items you wish to change in Section A. Complete Section B with your name and social security number. Fill in Section C and D with updated information.
5. ALL MEMBERS: Retain Pink Copy as Temporary I.D. Card for use until permanent card arrives.

Office Use Only

Group No	Subscriber No.	Effective Date
Pharmacy Code	**Benefit Code:**	

Section A

Check all that apply

___ Name , phone, address change
___ Physician/Pharmacy Change
___ Card Correction

Add Dependent(s)_____(date)
___ Marriage
___ Newborn, Adoption, Legal Guardianship
___ Other

Cancel Coverage_____ (date)
___ Dependents ___ All Coverage
Reasons (Check one)
___ Marriage/Divorce ___ Age Limit
___ Leave/Layoff ___ Term Employment
___ Out of Area ___ Voluntary Withdrawal

Cobra_____ (date)
___ Death, Divorce, Separation
___ Termination/Retirement
___ Reduction in work hours
___ Medicare Eligible
___ Loss of Dependent Eligibility

Reinstatement _____ (date)
___ Return from layoff, leave or Rehire
___ Disenrollment Error
___ Other

Section B

Last Name	First Name	Middle Initial	Social Security #

Section C

Address (Number, Street, Apartment)	City	State	Zip Code	Home Tel. No.
Date of Hire	Employer Name, Location			Work Tel. No.

Waiver of Coverage: I have been given an opportunity to apply for group medical coverage. I hereby waive coverage for: **( ) Myself ( ) My Spouse ( ) My Dependent Children.** If waiving for reason other than other health coverage, please indicate reason at bottom of this box. **Note**: If you are declining enrollment for yourself or your dependents (including spouse) because of other health insurance coverage, **please check this box [ ].** You may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. (Please stop here and sign and date form.) **Waiver Reason or Name of Other Insurance (Including Medicare)**:

Section D

Please use another sheet of paper for additional dependents.

Last , First , MI	Full Time Student Y/N	Member No.	Birthdate	Sex M/F	Soc. Sec. #	Other Insurance Including Medicare
Subscriber		01				
Spouse		02				
Child						
Child						

I hereby apply for myself and dependents, if any, listed hereon. The application is subject to acceptance, and if accepted, to the waiting periods, exclusions and other provisions contained in the subscription agreement(s) and authorize my employer, when applicable, to deduct charges from my pay and remit them to you. I agree that benefits payable under the Group Policy may vary depending upon whether services are provided by a participating or non-participating Provider. **AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMAITON**: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give the health plan/insurer and employer or any of their designees, any and all records or information, as permitted by law, pertaining to medical history or services rendered to Us for any administrative purposes, including evaluation of an application or claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original. I have carefully read this subscription application and agree to the terms specified herein. The foregoing statements are complete, true to the best of my knowledge and belief. **If you have any questions concerning benefits and services provided by or excluded under this agreement please contact Member Services at 1-800-844-7423.**

_____/_____ _____/_____
Employee Signature Date Employer Representative Signature Date