



**Coventry Health Care of Delaware, Inc.**  
 2751 Centerville Rd., Suite 400, Wilmington, DE 19808-1627  
 1-800-833-7423

Open Access HMO     HMO     State Continuation - Date \_\_\_\_\_  
 Open Access POS     POS     COBRA     Conversion - Date \_\_\_\_\_  
 Plan Name \_\_\_\_\_

**Maryland 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 and C.
4. CURRENT MEMBERS: Check all items you wish to change in Section A. Complete Section B. Fill in Section C with updated information (if applicable).
5. ALL MEMBERS: Retain Pink Copy as Temporary I.D. Card for use until permanent card arrives.

Office Use Only
Group Number:
Effective Date:

**Section A - Check all that apply**      **Enrollment Reason: € Open Enrollment**      **€ New Hire**      **€ Qualifying Event (see specifics below)**

<input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Telephone Change <input type="checkbox"/> Card Correction <input type="checkbox"/> Change Primary Care Physician (N/A to Open Access)	Add Spouse/Child _____ Date <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Other _____	Cancel Spouse/Child _____ Date <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Age Limit <input type="checkbox"/> Other _____	Cancel Dependents _____ Date <input type="checkbox"/> Terminate Employment <input type="checkbox"/> Voluntary Withdrawal <input type="checkbox"/> Leave/Layoff <input type="checkbox"/> Out of Service Area Move <input type="checkbox"/> Other _____ Continuation _____ Date Conversion _____ Date	COBRA _____ Date <input type="checkbox"/> Death <input type="checkbox"/> Termination <input type="checkbox"/> Reduction in work hours <input type="checkbox"/> Divorce/Separation <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Loss of Dependent Eligibility <input type="checkbox"/> Retirement	Reinstatement _____ Date <input type="checkbox"/> Return from layoff <input type="checkbox"/> Return from Leave <input type="checkbox"/> Rehire <input type="checkbox"/> Disenrollment <input type="checkbox"/> Other _____
---	--	---	--	--	--

**Section B – Please complete all boxes**

Subscriber's Last Name	First Name	Middle Initial	Social Security #
Address (Number, Street, Apartment)		City	State
Employer Name, Location		Zip Code	Home Tel. No. ( )
		Date of Hire	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 the 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 or your dependents, provided that you request enrollment within 31 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 C – Please complete all boxes.** 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*				Primary Care Physician (N/A to Open Access)	Current Patient Y/N
						Y/N	Name of Carrier	*Part A Eff. Date	*Part B Eff. Date		
Subscriber		01									
Spouse		02									
Child											
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). I agree that in order to qualify for HMO benefits that are not Open Access, services must be obtained from or authorized by the appropriate participating Health Plan provider, except for emergency and out-of-area services. **AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION:** 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 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 1-800-833-7423.**

\_\_\_\_\_/\_\_\_\_\_  
 Employee Signature      Date  
 CHC (MD) 100.2      White: CHC

\_\_\_\_\_/\_\_\_\_\_  
 Employer Representative Signature      Date  
 Yellow: Employer      Pink: Member