



Group Enrollment Form

Coventry Health Care
Enrollment Address

P.O. Box 2778, Bismarck, ND 58502 Fax # 701-250-5396

PPO Plan number: _____
 Qualified High Deductible Health Plan number: _____

- Please print or type all necessary information.
- Complete all items requested.
- NEW MEMBERS: Complete all items in Sections B,C, and D.
- CURRENT MEMBERS: Check all items you wish to change under Section A. Complete Section B with your name and social security number. Fill in Sections C and D with updated information.

Group Name:	Group Number:	Subscriber Number:	Effective Date:
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Section A (Check all that apply)

Date of Change: <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Telephone Change <input type="checkbox"/> Change Primary Care Physician	Add Dependent(s) <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Other	Cancel Dependent(s) only <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Age Limit <input type="checkbox"/> Other	Cancel All Coverage <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 <input type="checkbox"/> Continuation <input type="checkbox"/> Conversion	COBRA <input type="checkbox"/> Death <input type="checkbox"/> Termination <input type="checkbox"/> Reduction in Work Hours <input type="checkbox"/> Divorce/Separation <input type="checkbox"/> Loss of Dependent Eligibility <input type="checkbox"/> Retirement	Reinstatement <input type="checkbox"/> Return from Layoff <input type="checkbox"/> Return from Leave <input type="checkbox"/> Rehire <input type="checkbox"/> Disenrollment Error <input type="checkbox"/> Other
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Section B

Subscriber Last Name	First Name	Middle Initial	Social Security Number
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Section C

Street Address	City	State	Zip Code	Home Telephone Number
Date of Hire	Employer Name, Location			Work Telephone Number

Section D

Last Name, First Name, Middle Initial	Member Number	Birth Date MM/DD/YY	Sex M/F	Social Security Number	Other Health Insurance Including Medicare	Primary Care Physician (for some HMO plans)
Subscriber	01					
Spouse	02					
Child						
Child						
Child						
Child						

By signing this form, I am applying for covered services for which my family and I are eligible and I authorize my employer to deduct from my earnings any required contributions.

I agree on behalf of myself and those family members enrolled ("Dependents"), for whom I have the authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as my "Enrolled Family"), that Coventry Health Care of Kansas, Inc., Coventry Health and Life Insurance Company or their authorized representatives (collectively referred to as "Health Plan") 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 for treatment, payment or health care operations, as those terms are explained in detail in Health Plan's Notice of Privacy Practices and to the extent permitted by law.

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, autoimmune deficiency syndrome, AIDS related complex, human immunodeficiency virus or genetic conditions to Health Plan for Health Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law.

I represent the information to be complete and accurate to the best of my knowledge. I understand that my answers to the questions above will be used to determine eligibility for coverage.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PPO plans are underwritten by Coventry Health and Life Insurance Company and Administered by Coventry Health Care of Kansas, Inc. Any questions regarding this form should be directed to Coventry Health and Life Insurance Company.

Employee Signature
CHC-OK-APP-012.05.05

Date

White Copy: CHC

Yellow Copy: Employer

Pink Copy: Employee

CHKS0566