



# Enrollment/Change Form

## Instruction Sheet

**P**lease detach this instruction sheet and place it beside your Enrollment/Change Form to assist you in the proper completion of the form. **You must complete Sections, A, B, C, D, E on page 1 & G on page 2 completely** when enrolling, adding, or deleting a dependent. After completing and signing the form, discard this sheet and return the form to your employer. Your employer will then verify that all information given is correct and return the employee copy to you. **Please keep the blue copy for your records. If newly enrolling, your copy is to be used as your temporary I.D. card until your membership card arrives.**

### FOLLOW STEPS 1 THROUGH 4:

- 1** Please provide all information requested.
- 2** Be sure to complete the full name, sex, relationship to you, date of birth, social security number, and PCP's name and PCP ID for you and each family member you are enrolling. **Dependents not listed will not be covered.** Circle (S) if full time student or (D) if physically disabled.  
\*If change only, list only the dependent(s) that you are adding or deleting.
- 3 Very Important.** Read all sections of the enrollment form including the acknowledgement on the back page. Please print clearly and sign the application where indicated.

### CONDITIONS OF ENROLLMENT

1. **I hereby enroll for benefits for the person(s) listed, and agree that I and my family members shall abide by the provisions of coverage set forth in the Group Contract under which we are enrolled.**
2. **I understand** that the Group Contract will determine the rights and responsibilities of Member(s) and Coventry Health Care of Georgia and will govern in the event of conflict with other materials provided by my employer or Coventry Health Care of Georgia.
3. **I understand** that any material misrepresentation in answering the questions on this application or nonpayment of premium or copayment(s) may result in termination of coverage.
4. **I understand** that the effective date of coverage shall be determined by my employer according to the guidelines established between my employer and Coventry Health Care of Georgia.
5. **I authorize** any physician, hospital, other medical provider, and persons or organizations involved in utilization review, peer review, and other plan administrative duties to disclose to Coventry Health Care of Georgia any medical information relating to the individuals specified on this application.
6. **I understand** that all covered medical services must be performed or authorized by the member's Primary Care Physician or Coventry Health Care of Georgia and be obtained from a participating provider unless otherwise authorized by Coventry Health Care of Georgia.
7. **I authorize** deductions from my earnings of the required contribution, if any, toward the cost of Coventry Health Care of Georgia coverage (if applicable).
8. **I understand** that it is my responsibility to report to my employer any changes in the eligibility of the individuals listed or any change to the information I have provided on this Enrollment Form.
9. **I understand** that enrollment is effective on acceptance by Coventry Health Care of Georgia and will remain in effect until the employer's next open enrollment period, regardless of the continued participation of a particular provider.
10. **I understand** that coverage and benefits are contingent upon prompt payment of premiums.
11. **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**
12. **This managed care plan may not cover all your health care expenses. Read your Group Contract carefully to determine which health care services are covered. For questions, call 1-800-395-2545.**

# ENROLLMENT/CHANGE FORM

## A TO BE COMPLETED BY EMPLOYEE

LAST NAME	FIRST NAME	MI	M/F	BIRTH DATE / /	SOCIAL SECURITY NO. - -	<b>COVERAGE TYPE</b> <input type="checkbox"/> SINGLE <input type="checkbox"/> PARENT/CHILD <input type="checkbox"/> FAMILY <input type="checkbox"/> PARENT/CHILDREN <input type="checkbox"/> HUSBAND/WIFE <b>DATE OF HIRE</b> _____ <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED	<b>MARITAL STATUS</b> <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED (Date) _____ <input type="checkbox"/> DIVORCED (Date) _____ <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED
ADDRESS			PRIMARY CARE PHYSICIAN / PCP ID		WORK PHONE ( ) -		
CITY	STATE	ZIP CODE	COUNTY	HOME PHONE ( ) -			

## B FAMILY MEMBERS TO BE ENROLLED OR DELETED

ENROLL OR DELETE	FULL NAME (LAST, FIRST, MI)	SEX	RELATIONSHIP	BIRTH DATE	STUDENT OR DISABLED	SOCIAL SECURITY NO.	PRIMARY CARE PHYSICIAN (PCP)	PCP ID
E D		M / F	Spouse	/ /	S / D	- -		
E D		M / F		/ /	S / D	- -		
E D		M / F		/ /	S / D	- -		
E D		M / F		/ /	S / D	- -		

## C Complete this section for employers with 26-199 employees.

In the last 5 years have you or any member of your family listed on this application ever had treatment for or treatment recommended for any serious illness? Examples include but are not limited to the following: diseases of the heart, lungs, liver, or vascular system, AIDS, AIDS related disease, substance abuse, mental/nervous disorders, cancer, diabetes, congenital birth defects, organ transplants; or has anyone had surgery or incurred medical/pharmacy claims of more than \$5,000.  
 Is anyone currently pregnant?  Yes  No If yes, please complete section D below.

## D COMPLETE THIS SECTION IF "YES" WAS CHECKED IN SECTION C.

Name of individual treated \_\_\_\_\_ Nature of illness \_\_\_\_\_  
 Type of treatment \_\_\_\_\_ Treatment dates From: \_\_\_\_\_ To: \_\_\_\_\_  
 Name & Address of attending physician \_\_\_\_\_

I represent on behalf of myself and any person who shall have or claim any interest in said policy, that to the best of my knowledge and belief, all information submitted to Coventry Health Care of Georgia is complete and true, anti I agree that this information shall be taken as the basis of the issuance of coverage for me and for each of the eligible dependents listed. I understand that Coventry Health Care of Georgia reserves the right to rescind coverage if any supplied information is materially inaccurate or incomplete. All claims relating to such fraud or misrepresentation and changes incurred after the termination will become my liability. I understand and agree that the health care coverage carrier contacted will rely upon the above information and answers as the basis for establishing group premium rates applicable to such policy. I authorize any medical professional, hospital, clinic, or other medical or medically related facility that has any records on me or any dependent applying for coverage to furnish Coventry Health Care of Georgia any information requested. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through Coventry Health Care of Georgia. For underwriting purposes, this authorization is valid for thirty months from the date the authorization is signed. I understand that a photocopy of this form is valid as the original and that either I or my authorized representative can receive a copy of this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## E PLAN: (Please Circle One) GOLD VALUE PREMIER MAX CHOICE VALUE PREMIER PLUS FLEX OPTION PLAN

\_\_\_\_\_  
 EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## F EMPLOYER INFORMATION (To Be Completed By Employer)

GROUP NO.	GROUP NAME	EFFECTIVE DATE / /	EMPLOYER'S SIGNATURE	DATE / /
<b>ENROLL</b> <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> NEW HIRE <input type="checkbox"/> REINSTATE		<b>CHANGE</b> <input type="checkbox"/> ADD DEPENDENT (reason for addition) _____ <input type="checkbox"/> DELETE DEPENDENT (reason for deletion) _____ <input type="checkbox"/> ADDRESS CHANGE		<input type="checkbox"/> CANCEL COVERAGE (reason) _____ <input type="checkbox"/> NAME CHANGE PREVIOUS NAME _____

**IMPORTANT: ALL FIELDS ON THIS FORM MUST BE COMPLETED FOR TIMELY PROCESSING.** (TO BE COMPLETED BY CHC OF GEORGIA)  
 DATE RECEIVED \_\_\_\_\_

## Acknowledgement Form

I understand that I am enrolling in a health care plan that may require that health care services be provided by participating providers. I also understand that failure to use a participating provider may result in reduced coverage or no coverage for services that I receive, and I will be fully responsible for any and all costs not covered by Coventry Health Care of Georgia, Inc. I understand that my Evidence/Certificate of Coverage provides additional details explaining the use of participating and non-participating providers under the plan.

I have received a complete list of the participating providers. I understand that the provider's participation status may change from time to time and it is my responsibility to verify the provider's participation status prior to receiving services. I understand that I may verify provider status in one of two ways. First, by checking Coventry Health Care of Georgia's website ([www.chcga.com](http://www.chcga.com)) that is updated at least every 30 days. Second, I may call customer service at the number listed on my member ID card.

As required by the State of Georgia, Coventry Health Care of Georgia provides the following summary of financial arrangements with the health care providers who are participating in the Coventry Health Care of Georgia network:

- 1) Hospital providers are paid according to a contract that includes inpatient per diems, case rates and discounted fee for service arrangements depending on a specific service provided.
- 2) Physicians are paid discounted fee for service in accordance with a specific fee schedule which has been provided to them as contracted.
- 3) Laboratory services are provided through a capitated per member per month flat fee. Other ancillary services including home health, skilled nursing and hospice are paid on a contracted fee schedule with per diems or per visit amounts.

<b>G OTHER INSURANCE</b>	<b>Do you or your dependents have other coverage? No _____ If Yes complete the following:</b>		
<b>List all family members with medical health insurance in addition to Coventry Health Care of Georgia</b>			
POLICY HOLDER	BIRTH DATE / /	EMPLOYER	INSURANCE COMPANY
LIST DEPENDENTS COVERED	EFF. DATE / /	CONTRACT NO./GROUP NO.	
Do you or your dependents have Medicare Coverage? _____ Yes _____ No If Yes, please complete the following:			
NAME	MEDICARE ID NO.	PART A EFF. DATE	PART B EFF. DATE