HEALTH AMERICA
HEALTHASSURANCE
Coventry Health Care Plans

Enrollment / Change Form

PA Online

* Denotes required fields for enrollment. For items with ** please select a Reason for Enrollment **OR** a Reason for Change.

A EMPLOYER INFORMATION: To Be Completed By Employer

☐ **New Group** ☐ **New Enrollment** ☐ **Change** ☐ **Waive**

*Company Name:

*Group No.:

Date Employed Full Time: ☐☐/☐☐/☐☐☐☐

*Effective Date of Coverage or Change ☐☐/☐☐/☐☐☐☐

****REASON FOR ENROLLMENT**

- ☐ New Group:
- ☐ New Hire:
- ☐ COBRA:
- ☐ Retired:
- ☐ Open Enrollment:
- ☐ Qualifying Event (Reason):

Date _____/_____/_____

****REASON FOR CHANGE:**
(Please check all that apply and include supporting documentation.)

- ☐ Enroll Dependent
- ☐ Terminate Dependent
- ☐ Terminate Subscriber
- ☐ Name Change (Previous Name)
- ☐ Address/Phone
- ☐ PCP Change

Termination Reason:
☐ Group Request ☐ Member Request ☐ Deceased

EMPLOYEE STATUS:
☐ Active ☐ COBRA ☐ Salary ☐ Hourly Number of hours a week _____ ☐ Other _____

Benefits Administrator Approval:

Date:

B SUBSCRIBER INFORMATION

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS: ☐ **None / Waive (please complete section E)**

☐ HMO[1] _____ ☐ POS[2] _____ ☐ PPO[3] _____ ☐ Other _____

Type of Coverage: ☐ Single ☐ Couple ☐ Employee/Child ☐ Employee/Children ☐ Family

*Last Name

*First Name

MI

*Gender ☐ Male ☐ Female

*Birthdate ☐☐/☐☐/☐☐☐☐

*Social Security Number ☐☐☐-☐☐-☐☐☐☐

*Address

*City

*State

*Zip Code

Email Address

Marital Status (please check one.)
☐ Single/Widowed ☐ Married ☐ Divorced ☐ Separated

▲Primary Care Physician ID# Site Code

Current Patient ☐ Yes ☐ No

Work Phone ☐☐☐-☐☐☐-☐☐☐☐

Home Phone ☐☐☐-☐☐☐-☐☐☐☐

C ☆FAMILY MEMBERS TO BE COVERED OR DELETED

☐ Add ☐ Delete

*Last Name

*First Name

MI

*Gender ☐ Male ☐ Female

*Relationship ☐ Child ☐ Other _____

Student / Disabled ☐ Student ☐ Disabled

*Birthdate ☐☐/☐☐/☐☐☐☐

Social Security Number ☐☐☐-☐☐-☐☐☐☐

▲Primary Care Physician ID# Site Code

Current Patient ☐ Yes ☐ No

☐ Add ☐ Delete

*Last Name

*First Name

MI

*Gender ☐ Male ☐ Female

*Relationship ☐ Child ☐ Other _____

Student / Disabled ☐ Student ☐ Disabled

*Birthdate ☐☐/☐☐/☐☐☐☐

Social Security Number ☐☐☐-☐☐-☐☐☐☐

▲Primary Care Physician ID# Site Code

Current Patient ☐ Yes ☐ No

Applicant Name: ______________________________

☐ Add ☐ Delete — *Last Name | *First Name | MI

*Gender: ☐ Male ☐ Female
*Relationship: ☐ Child ☐ Other ________
Student / Disabled: ☐ Student ☐ Disabled
*Birthdate: __ __ / __ __ / __ __ __ __
Social Security Number: ___ - __ - ____
▲Primary Care Physician ID# Site Code
Current Patient: ☐ Yes ☐ No

☐ Add ☐ Delete — *Last Name | *First Name | MI

*Gender: ☐ Male ☐ Female
*Relationship: ☐ Child ☐ Other ________
Student / Disabled: ☐ Student ☐ Disabled
*Birthdate: __ __ / __ __ / __ __ __ __
Social Security Number: ___ - __ - ____
▲Primary Care Physician ID# Site Code
Current Patient: ☐ Yes ☐ No

☐ Add ☐ Delete — *Last Name | *First Name | MI

*Gender: ☐ Male ☐ Female
*Relationship: ☐ Child ☐ Other ________
Student / Disabled: ☐ Student ☐ Disabled
*Birthdate: __ __ / __ __ / __ __ __ __
Social Security Number: ___ - __ - ____
▲Primary Care Physician ID# Site Code
Current Patient: ☐ Yes ☐ No

☐ Add ☐ Delete — *Last Name | *First Name | MI

*Gender: ☐ Male ☐ Female
*Relationship: ☐ Child ☐ Other ________
Student / Disabled: ☐ Student ☐ Disabled
*Birthdate: __ __ / __ __ / __ __ __ __
Social Security Number: ___ - __ - ____
▲Primary Care Physician ID# Site Code
Current Patient: ☐ Yes ☐ No

☐ Add ☐ Delete — *Last Name | *First Name | MI

*Gender: ☐ Male ☐ Female
*Relationship: ☐ Child ☐ Other ________
Student / Disabled: ☐ Student ☐ Disabled
*Birthdate: __ __ / __ __ / __ __ __ __
Social Security Number: ___ - __ - ____
▲Primary Care Physician ID# Site Code
Current Patient: ☐ Yes ☐ No

D OTHER MEDICAL AND/OR PHARMACY COVERAGE INFORMATION

When coverage with HealthAssurance begins, will you or any of your family members have any other medical insurance coverage? ☐ **Yes** ☐ **No**

If you answered yes, please complete the following:

COVERAGE TYPE:
☐ Group Policy ☐ Individual Policy ☐ Medicare ☐ Pharmacy ☐ Medicaid ☐ TRICARE ☐ Other ________

Other Insurance Company Name | Policy Holder Name | Covered Dependents

Gender: ☐ Male ☐ Female
Relationship: ☐ Spouse ☐ Child ☐ Other ________
Birthdate: __ __ / __ __ / __ __ __ __
Effective Date of Other Insurance: __ __ / __ __ / __ __ __ __

Other Insurance Company Name | Policy Holder Name | Covered Dependents

Gender: ☐ Male ☐ Female
Relationship: ☐ Spouse ☐ Child ☐ Other ________
Birthdate: __ __ / __ __ / __ __ __ __
Effective Date of Other Insurance: __ __ / __ __ / __ __ __ __

E WAIVER My employer has given me an opportunity to apply for group health coverage for myself and my dependents (if applicable)

I have declined to apply for coverage for ☐ Myself ☐ Spouse ☐ Dependents

Reason for decline: ☐ Other health insurance ☐ Spousal coverage ☐ Other reason (please explain)

I understand that if I decide to apply for health coverage for myself and any applicable dependents at a later date, neither my dependents nor I will be eligible for coverage until (1) my employer's next open enrollment period, or (2) there is a qualifying event as defined in the EOC/COI/GCSA.

Employee Signature (only if you are waiving coverage) Date:

F AGREEMENT AND AUTHORIZATION Please read the following carefully.

I AGREE: All information on this form and the attached health questionnaire is correct and true. I understand that it is the basis on which premiums may be determined under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment at least 25 hours a week. Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded. I ACKNOWLEDGE THAT I am applying for Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or Coordinated Care Preferred Provider Organization (POS) coverage. I understand if I or one of my dependents receive medically necessary covered services from a non-participating provider, HealthAssurance or HealthAmerica will only cover the lower level benefits set forth in the applicable group contract and I will be responsible for payment of any amount not covered by HealthAssurance or HealthAmerica. I understand that in the case of HealthAmerica HMO and HealthAssurance HMO, all covered medical services must be performed by a participating provider or my Primary Care Physician, and that some services must be authorized by HealthAmerica or HealthAssurance. AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION. I authorize any insurance company, physician, hospital, clinic, health care provider or other organization, institution or person having records or knowledge of anyone listed on this application to give HealthAmerica/HealthAssurance or their designated agent any and all records pertaining to any medical history, services or treatment provided to anyone on this application for purposes of review, investigation or evaluation of coverage. This authorization is valid as the original. I, the applicant, acknowledge that I have read and understand the Application in its entirety.

OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

PENNSYLVANIA APPLICANTS: 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.

ELECTRONIC COMMUNICATIONS: I ACKNOWLEDGE AND UNDERSTAND THAT BENEFIT DOCUMENTS AND PROVIDER NETWORK INFORMATION FOR HEALTHAMERICA PLANS WILL BE MADE AVAILABLE TO ME IN ELECTRONIC FORMAT THROUGH THE HEALTHAMERICA WEBSITE AND MY ONLINE SERVICES AT WWW.HEALTHAMERICA.CVTY.COM. MY ENROLLMENT IN THE PLAN INCLUDES THIS ELECTRONIC ACCESS. TO RECEIVE PRINTED DOCUMENTS AT NO COST TO ME, I MUST CONTACT CUSTOMER SERVICE TOLL-FREE AT 1-800-788-8445 IN CENTRAL AND EASTERN PA OR 1-800-735-4404 IN WESTERN PA AND OH.

I HAVE READ AND AGREE TO THE STATEMENTS ABOVE. (Signature Required Below)

Applicant Signature **Date**

Applicant Printed Name

GENERAL PROVISIONS

For members enrolled in the HealthAmerica HMO or HealthAssurance HMO: HMO products are made available through HealthAmerica Pennsylvania, Inc. For members enrolled in Pennsylvania HealthAssurance PPO and CCPPO (POS): HealthAssurance products are made available through HealthAssurance Pennsylvania, Inc. For Ohio and out-of area members enrolled in the HealthAssurance PPO: HealthAssurance products are made available through Coventry Health & Life Insurance Company. If you have any questions about which products you are enrolling in, call our member services at 800-788-8445 in central and eastern PA and 800-735-4404 in western PA and OH or contact your employer.

1. ENROLLMENT RIGHTS NOTICE (Waived Coverage) - I understand that if I and/or any of my dependents, if any, waive coverage at this time and desire to participate in the plan at a future date, coverage could be subject to treatment as a late enrollee at that time. I further understand that even if I decline enrollment for myself or my dependents, spouse included, because of other health coverage at this time, I will still have the right to enroll myself and/or my dependents in this plan, provided I request enrollment within thirty-one (31) days of the time that such coverage ends. I also understand that if a new dependent relationship is formed due to marriage, birth, adoption, placement for adoption, or court order, I may be able to enroll myself and/or my dependents provided I request enrollment within thirty-one (31) days of such marriage, birth, adoption, placement for adoption or court order.

2. RESOLUTION OF DISPUTES - Please refer to the Group Contract and Subscription Agreement, Evidence of Coverage and/or Certificate of Insurance, which outlines in detail HealthAmerica or HealthAssurance's Member Complaint and Appeals Procedure.

1 Underwritten by HealthAmerica Pennsylvania, Inc.
2.Underwritten by HealthAssurance Pennsylvania, Inc. Not available in Ohio.
3 Underwritten in PA by HealthAssurance Pennsylvania, Inc., and in OH and out-of-area by Coventry Health and Life Insurance Company.
▲Complete if enrolling in HMO or POS. PCP ID is found in the Provider Directory or at www.healthamerica.cvty.com.
☆If address and phone numbers of covered dependents are different from that of policyholder, please attach that information on a separate sheet of paper.