Georgia
Application for Coventry Individual Health Insurance

Coventry Health Care of Georgia, Inc.

Primary Applicant's Name

Applicant's Social Security Number

INSTRUCTIONS:

- **Please complete in blue or black ink only. PRINT clearly.**
- **The information you provide is confidential.**
- **All answers must be true, complete and truthful.**
- **Intentional misrepresentation may result in the policy being modified or terminated.**
- **Proof of state residency may be required**

NOTICE - YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

Section A – Primary Applicant Information (for parent/guardian for Child-Only application)

Primary Applicant Last Name	First Name	Middle Initial
Home Address (No PO Boxes)		Apt. Number
City	State	ZIP Code
Relationship (If Child-Only Application)		
Mailing Address (If different from your Home address)		
City	State	ZIP Code
County	E-mail Address	
Telephone Number **Home** (_____)_____ **Work** (_____)_____ **Mobile** (_____)_____	If we need to call you with any question about your application, when is the best time to reach you? ☐ Morning ☐ Afternoon ☐ Evening	

Section B – Coverage Information

Application Type (Select one):

Annual Open Enrollment Period

☐ New medical coverage ☐ Child-Only Application (Children up to age 21)

☐ Change current coverage ☐ Add dependent(s) to current coverage

Your Effective Date will be assigned by Coventry, based on your signature date.

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Section C – Special Enrollment Period

If you are applying outside of the Annual Open Enrollment Period and one of the events listed below applies to you, check the appropriate box. The Special Open Enrollment Period begins on the date of the event checked and continues for 60 days.

Date of Event	Event
_____	☐ Loss of employer coverage due to termination of employment, reduction in hours, or coverage no longer offered to my employment class, loss of COBRA coverage.
_____	☐ Loss of employer or individual coverage because no longer eligible as a dependent.
_____	☐ Loss of employer or individual coverage because of divorce from policyholder, death of policyholder, or policyholder enrolled in Medicare.
_____	☐ Loss of Medicaid or CHIP coverage.
_____	☐ Coverage needed for new dependent through marriage.
_____	☐ Coverage needed for new dependent through birth, adoption or placement for adoption.
_____	☐ Coverage needed following loss of eligibility for Exchange subsidies.
_____	☐ A permanent move.
_____	☐ Other, please explain. _____

Section D – Coverage Selection

Choose the plan that best meets your needs.

Bronze:	**Silver:**	**Gold:**
☐ Bronze $20 Copay POS PD ☐ Bronze Ded Only HSA Elig POS PD	☐ Silver $10 Copay POS PD ☐ Silver $5 Copay 2750 POS PD	☐ Gold $5 Copay POS PD
Albany HMO Available in the following counties: Baker, Dougherty, Lee, Sumter, Terrell, Worth		
☐ Bronze $20 Copay HMO PD Albany ☐ Bronze Ded Only HSA Elig HMO PD Albany	☐ Silver $10 Copay HMO PD Albany ☐ Silver $5 Copay 2750 HMO PD Albany	☐ Gold $5 Copay HMO PD Albany
Atlanta HMO Available in the following counties: Cherokee, Dawson, DeKalb, Forsyth, Fulton, Gwinnett, Newton, Rockdale		
☐ Bronze $20 Copay HMO PD Atlanta ☐ Bronze Ded Only HSA Elig HMO PD Atlanta	☐ Silver $10 Copay HMO PD Atlanta ☐ Silver $5 Copay 2750 HMO PD Atlanta	☐ Gold $5 Copay HMO PD Atlanta
Columbus HMO Available in the following counties: Chattahoochee, Harris, Marion, Muscogee, Stewart		
☐ Bronze $20 Copay HMO PD Columbus ☐ Bronze Ded Only HSA Elig HMO PD Columbus	☐ Silver $10 Copay HMO PD Columbus ☐ Silver $5 Copay 2750 HMO PD Columbus	☐ Gold $5 Copay HMO PD Columbus
Hall HMO Available in the following counties: Hall		
☐ Bronze $20 Copay HMO PD Hall ☐ Bronze Ded Only HSA Elig HMO PD Hall	☐ Silver $10 Copay HMO PD Hall ☐ Silver $5 Copay 2750 HMO PD Hall	☐ Gold $5 Copay HMO PD Hall
Macon HMO Available in the following counties: Bibb, Crawford, Houston, Jones, Monroe, Peach, Twiggs		
☐ Bronze $20 Copay HMO PD Macon ☐ Bronze Ded Only HSA Elig HMO PD Macon	☐ Silver $10 Copay HMO PD Macon ☐ Silver $5 Copay 2750 HMO PD Macon	☐ Gold $5 Copay HMO PD Macon
Savannah HMO Available in the following counties: Bryan, Chatham, Effingham, Liberty		
☐ Bronze $20 Copay HMO PD Savannah ☐ Bronze Ded Only HSA Elig HMO PD Savannah	☐ Silver $10 Copay HMO PD Savannah ☐ Silver $5 Copay 2750 HMO PD Savannah	☐ Gold $5 Copay HMO PD Savannah

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SEGA HMO Available in the following counties: Appling, Coffee, Emanuel, Wayne		
☐ Bronze $20 Copay HMO PD SEGA ☐ Bronze Ded Only HSA Elig HMO PD SEGA	☐ Silver $10 Copay HMO PD SEGA ☐ Silver $5 Copay 2750 HMO PD SEGA	☐ Gold $5 Copay HMO PD SEGA
Valdosta HMO Available in the following counties: Berrien, Clinch, Echols, Lanier, Lowndes		
☐ Bronze $20 Copay HMO PD Valdosta ☐ Bronze Ded Only HSA Elig HMO PD Valdosta	☐ Silver $10 Copay HMO PD Valdosta ☐ Silver $5 Copay 2750 HMO PD Valdosta	☐ Gold $5 Copay HMO PD Valdosta

Health Savings Account (HSA) If you have selected a Bronze Deductible Only plan, you are eligible to open a Health Savings Account (HSA) through our HSA trustee, HealthEquity. After enrollment, you will receive information from HealthEquity with instructions to set up your HSA account.

Section E – Persons Requesting Coverage

List all family members you wish to be covered under this policy.

Dependent children are eligible up to age 26.

For a Child-Only application, start listing children at Child 1 with the youngest child listed first.

☐ Check here if more space is needed to provide information for additional dependents. Use a separate sheet of paper and staple to the back of this application.

If any person has regularly used tobacco products (cigarettes, pipe, cigars, snuff, or chewing tobacco) within the last 6 months, check Yes as Tobacco User below. Regular use means an average of four or more times per week.

A list of participating providers can be found at www.coventryone.com by selecting the ***Find a Doctor*** link.

Primary Applicant Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Spouse/Domestic Partner Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 1 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 2 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 3 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 4 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 5 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No

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Section E – Persons Requesting Coverage (Continued)

To be completed by the primary Applicant

Marital Status ☐ Married ☐ Domestic Partner ☐ Single	Are you a resident of the state in which you are applying? ☐ Yes ☐ No
How would you like Coventry to communicate with you regarding your application and coverage? ☐ E-mail ☐ Mail ☐ Text	Would you like to receive emails from us regarding your benefits, programs and general health information? ☐ Yes ☐ No

Would you like to turn off paper? ☐ Yes ☐ No

If you turn off paper, we will send you emails about your claims and other activity on your account. You can also view your statements and communications online.

Please note that there may be state or federal regulations that prohibit us from communicating with you in your preferred method in some instances.

Are any applicants enrolled in or entitled to Medicare benefits? ☐ Yes ☐ No

If Yes, provide name(s) of these applicants:_____

Are all applicants listed on this application Citizens of the United States? ☐ Yes ☐ No

If "No," provide Name and most recent date of arrival in the U.S.

Proof of state residency will be required.

Name	Most recent arrival date

Do you read and write English? ☐ Yes ☐ No (If No, the Statement of Accountability must be completed.)

If "No," Primary Spoken Language: _____ Primary Written Language: _____

Did you complete this application? ☐ Yes ☐ No (If No, the Statement of Accountability must be completed.)

Statement of Accountability – Must be completed if the applicant answered "No" to read or write English or the applicant did not complete this application.

I _____, acting as (describe your relationship) _____ have personally read this form to the applicant and completed the application because:

☐ Applicant does not have sufficient command of the English language to complete this application

☐ Applicant is legally incapacitated and unable to complete this application

I have read and explained in detail the contents of this application.

_____

If translated, I also fully explained to the applicant the "Authorization to Disclose Personal Health Information" and "Signature(s) Required" under **Sections F and H**.

Signature of Representative ***(Required)***	Today's Date ***(Required)***

Print Name

Street Address

City	State	ZIP Code	Telephone Number ( )

Primary Applicant's Name

Section F – Authorization to Use and Disclose Protected Health Information

Please read the following carefully before completing your authorization. You may refuse to sign this authorization.

Purposes of this Authorization Form
By signing this form, I authorize Coventry, or Coventry's representatives, to request, receive and use Protected Health Information (PHI), including but not limited to, prescribed medication history or other pharmaceutical information, hospital records, physician records, claims or benefit records or lab results for the following purposes: a) to verify tobacco use, b) to coordinate medical care and case management, and/or c) for risk adjustment activities. I authorize Coventry to disclose my PHI for the purposes stated above to other persons or organizations performing services on Coventry's behalf.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, lab, pharmacy, pharmacy benefit manager or other medical or medically related facility, insurance or reinsuring company, or other organization, institution, or person that has any record or knowledge of my health to disclose such information to Coventry to the extent permitted by law.

I understand that Coventry may pay a fee to a third party to collect my health information. The health information released to Coventry may be related to chronic diseases, mental illness, alcohol or substance abuse, Human Immunodeficiency Virus (HIV) infection, or Acquired Immune Deficiency Syndrome (AIDS),

Coventry may not condition your treatment, payment, enrollment or eligibility for benefits, on whether or not you sign this authorization.

Health information received by Coventry will not be re-disclosed without your authorization unless permitted by law, as described in Coventry's Notice of Privacy Practices. Information that is re-disclosed may not be protected under federal privacy laws.

Term of Authorization
I agree this Authorization shall be valid for eighteen (18) months from the signature date below.

Right to Revoke
I understand that I may revoke this authorization at any time by giving advance written notice to Coventry. My revocation will not have any effect on actions Coventry has already taken before receiving my notice.

Primary Applicant's or Parent/Guardian's Signature	Date
Spouse / Domestic Partner's Signature	Date
Dependent's signature (age 18 or older)	Date
Dependent's signature (age 18 or older)	Date

Primary Applicant's Name

Section G – Payment Options (Select the method of payment for your initial application and following premium payments.)

Initial Payment

☐ Electronic Fund Transfer (complete the EFT information below)

☐ Monthly Billing Statement (subject to a $5 administrative fee)

Recurring or Follow Up Payments

☐ Electronic Fund Transfer (complete the EFT information below)

☐ Monthly Billing Statement (subject to a $5 per month administrative fee)

Payroll Deduction Program (PDP) / Employer List Bill (ELB)

This program allows your premium to be deducted directly from your paycheck, on a post-tax basis. Other details apply. To choose this option, you MUST submit a separate Payroll Deduction Authorization Form with your application.

☐ New Payroll Deduction Program (PDP) / Employer List Bill (ELB)

☐ Existing Payroll Deduction Program (PDP) / Employer List Bill (ELB)

ELB Number: _____

ELB Name: _____

Electronic Fund Transfer – EFT

Upon issuance, the first month's premium will automatically be withdrawn from the listed bank account. The following monthly premiums will be withdrawn automatically from the bank account listed on the application on the 5th day (or the following business day if a weekend or holiday) in the month for which premium is due. The premium amount due is calculated per day, so if the effective date is anything other than the 1st of the month, the following premium payment will be prorated.

Account Number: _____

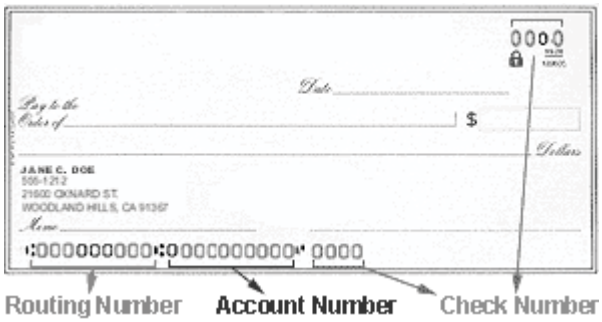
Routing Number: ☐☐☐☐☐☐☐☐☐

Token: _____

Name(s) on Account: _____

Account Holder Address : _____

☐ Checking ☐ Savings



Any rate adjustment made in accordance with the enrollment process will be automatically charged to your account upon approval of your application. Please be advised that tobacco use may result in an increase to the standard premium.

Important Note: Coventry*One* is not an employer-sponsored group health plan. If your banking information is from a business account, or you are submitting a check drawn from a business account, you must contact us / your agent to complete a Coventry*One* Payroll Deduction / Employer List Bill (ELB) Authorization Form.

By signing this Premium Payment section, you are agreeing to the following statements:

- You understand that it is your responsibility to immediately notify Coventry at 1-866-364-5663 should your payment or address information change at any time while you continue to hold a Coventry*One* policy.
- You understand that if premium payment is returned unpaid, a fee will be assessed in the amount of $20.00. Failure to remit the first payment could result in rescission back to your effective date.
- You understand that providing this payment information does not guarantee approval for coverage.
- Upon issuance of this Application, you authorize Coventry to initiate an immediate automatic withdrawal and / or a billing cycle of applicable premium payments from your provided account or billing information. If your effective date is entered into the system after the third business day of the month, your following automatic withdrawal may include premium amounts for multiple months.
- I agree this authorization will remain in effect until I provide written notification terminating this service.

Account / Card Holder Signature	**Date**

Primary Applicant's Name

Section H – Signature(s) Required – All Applicants (Primary/Spouse and dependents) age 18 and older must read and sign this form below.

By signing this form you agree to the following:

1. The answers in this application are true and complete to the best of my knowledge and belief.
2. The children listed on this application are my legal dependents.
3. I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by Coventry, and may face legal liability, including legal action based on fraud.
4. I have read this entire application, or it has been read to me.
5. The information I have provided in this application will be used by Coventry to determine whether to issue coverage and the premium amount for such coverage.
6. No coverage shall be in force until Coventry processes this application and Coventry has notified me of my effective date.
7. This application will become part of the contract between Coventry and me.
8. I or my legal representative has the right to receive a copy of this application upon request. I agree that a photocopy shall be as valid as the original. A legal facsimile signature shall have the same force and effect as the original.
9. I authorize Coventry to electronically transmit the information contained in this application.

Primary Applicant's or Parent/Guardian's Signature	Date
Spouse / Domestic Partner's Signature	Date
Dependent's signature (age 18 or older)	Date
Dependent's signature (age 18 or older)	Date

Primary Applicant's Name

Section I – Insurance Producer or Agent (Required If Applicable)

Complete if Broker of Record is an Individual Producer (not an Agency)

Print Name of Producer	NPN of Agent
Signature of Producer (required if applicable)	Telephone Number ( )
E-mail Address	Fax Number ( )
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	

Complete if Broker of Record is an Agency

Name of Agency	TIN of Agency	
E-mail Address	Telephone Number ( )	Fax Number ( )
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)		
Print Name of Producer Representing Agency	NPN Number	
Signature of Agency Representative (required if applicable)		

General Agent

Print Name of General Agent	TIN of General Agent
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	

Coventry Sales Representative

Last Name of Agent (Print Name)	First Name of Agent (Print Name)	License Number

Section J – Contact Information

Please return this application to the agent or submit to the address listed below.

Coventry Individual Plans
PO Box 31217
Tampa, FL 33631-3217

Fax #: 877-904-7822
Email: cvtynewapps@healthplan.com
Website for information: www.coventryone.com