CoventryOne. Underwritten by Coventry Health Care of Georgia, Inc.

FOR INTERNAL USE ONLY
EL CODE_____
☐ ACH ☐ NON-ACH
☐ HSA OPT-OUT ☐ PDP

FOR BROKER USE ONLY
Amount quoted for requested effective date:

$_____ / Month
☐ Individual ☐ Family

Payroll Deduction Program (PDP)
☐ Not Applicable

Name of PDP
_____

Application / Health Statement Form

To ensure timely processing of this Application:
- Use only blue or black ink
- All questions must be answered completely and accurately
- The Application must be signed and dated in each required section by all required Applicants
- All corrections must be initialed and dated; correction fluid is not permitted
- This Application is valid sixty (60) days from the earliest date of signature in the Conditions of Enrollment section.

Check all that apply:

☐ New Application ☐ Plan Benefits Increase ☐ Dependent Add

☐ Reinstatement ☐ New Minor Child-Only Application *(under 18 years old)*

REQUESTED EFFECTIVE DATE
☐ 1st day of _____20_____
☐ 15th day of _____20_____

Applicant and Dependent Information

Primary Applicant *If Minor Child-Only Application, complete information about the child(ren)'s parent or legal guardian in this section.*

Last name	First name			MI	Home phone ( ) -
Residence address	City	State	ZIP code	County	
E-mail address	Occupation / Title			Business phone ( ) -	
Best time and place to receive a call from Coventry regarding this Application, if necessary: ☐ Home ☐ Business ☐ Other (____)_____ ☐ Morning ☐ Afternoon ☐ Evening				Relationship *(if Minor Child-Only Application)*	
Mailing address *(If different from address above)*	City	State	ZIP code		

Primary Applicant's Spouse *(If applying for coverage in this Application)*

Last name	First name			MI	Home phone ( ) -
Residence address	City	State	ZIP code	County	
E-mail address	Occupation / Title			Business phone ( ) -	
Best time and place to receive a call from Coventry regarding this Application, if necessary: ☐ Home ☐ Business ☐ Other (____)_____ ☐ Morning ☐ Afternoon ☐ Evening					
Mailing address *(If different from address above)*	City	State	ZIP code		

Applicant Name:_____ **Broker:**_____

Primary Applicant and All Dependents Applying for Coverage

1. Are all persons applying for coverage in this Application legal residents of the United States? ☐ **Yes** ☐ **No**
2. Have all persons applying for coverage in this Application legally resided in the United States for the past six (6) consecutive months? ☐ **Yes** ☐ **No**

   If no, indicate person(s): _____

   Country of residency: _____ Date of entry into the United States (mm/yyyy): _____

3. List Primary Applicant and all Dependents applying for coverage in this Application:

Full Name (Last, First, MI)	**Gender** (circle one)	**Relationship to the Primary Applicant**	**Age**	**Birthdate** (mm/dd/yyyy)	**Disabled dependent?**[1]	**Social Security Number**	**Height** (ft. in.)	**Weight** (lbs.)	**Tobacco use?**[2]
1.	M / F	SELF			N/A				☐ Yes ☐ No
2.	M / F	SPOUSE			N/A				☐ Yes ☐ No
3.	M / F				☐ Yes ☐ No				☐ Yes ☐ No
4.	M / F				☐ Yes ☐ No				☐ Yes ☐ No
5.	M / F				☐ Yes ☐ No				☐ Yes ☐ No
6.	M / F				☐ Yes ☐ No				☐ Yes ☐ No
7.	M / F				☐ Yes ☐ No				☐ Yes ☐ No

[1] Please check the appropriate box if the listed dependent is disabled.
[2] 'Tobacco use' constitutes use of tobacco or tobacco cessation products in the past twelve (12) months. If yes, provide details in the Lifestyle Additional Information Section

4. Are all of the Primary Applicant's dependent children accounted for in this Application for coverage? ☐ **Yes** ☐ **No** ☐ **N/A**

   If no, explain: _____

5. Is anyone applying for coverage in this Application required to provide health care coverage for a child pursuant to a qualified medical child support order or other court order? ☐ **Yes** ☐ **No** ☐ **N/A**

   If yes, explain: _____

6. Do all dependent children included in this Application reside with the Primary Applicant? ☐ **Yes** ☐ **No** ☐ **N/A**

   If no, complete the Custodial Parent section below. *Note that the Custodial Parent must also sign the Authorization of Release of Information and Conditions of Enrollment Sections of this Application.*

Child Name (Last, First, MI)	**Custodial Parent Name** (Last, First, MI)	**Custodial Parent Address**	**Relationship to child**
1.			
2.			
3.			

Plan Selection

Indicate one (1) plan selection below for which all Applicants are applying.

☐ $20 Copay POS $ 500
☐ $20 Copay POS $1,000
☐ $20 Copay POS $2,000
☐ $20 Copay POS $3,000
☐ $20 Copay POS $4,000
☐ $20 Copay POS $5,000
☐ $20 Copay POS $10,000

☐ $35 Copay POS $1,000
☐ $35 Copay POS $2,500
☐ $35 Copay POS $3,500
☐ $35 Copay POS $5,000
☐ $35 Copay POS $7,500
☐ $35 Copay POS $10,000

☐ QHDHP POS $1,250/ $2,500
☐ QHDHP POS $3,000/ $5,500
☐ QHDHP POS $5,000/ $10,000

☐ Fusion POS $3,000
☐ Fusion POS $5,000

☐ Mental Health Rider **(MH Rider is optional with POS & Fusion Plans)**

☐ Consumer Choice Option

If plan selection is a Qualified High Deductible Health Plan (QHDHP), proceed to the Health Savings Account (HSA) Selection section if you wish to open an HSA.
Mental Health Rider is optional with Copay and Fusion Plans only, **for an additional cost**. Mental Health benefits are built into QHDHPs.

Applicant Name:_____ **Broker:**_____

Health Savings Account (HSA) Selection

This section is only applicable when the plan selected in the Plan Selection section is a Qualified High Deductible Health Plan (QHDHP). If Plan Selection is not a QHDHP, skip to the Other Health Insurance Information section.

Your Health Savings Account (HSA) is your financial asset even if you change health plans or are no longer covered by Coventry*One*. To open an HSA, you must meet three (3) criteria:

1. You must be covered by a QHDHP;
2. You cannot be covered by another health plan, including Medicare; and
3. You cannot be claimed as a Dependent on another individual's tax return.

If you have selected a Coventry*One* QHDHP and are otherwise eligible, you will receive a HSA through our HSA trustee, HealthEquity, at no additional charge. You will be able to contribute to this tax-advantaged account to help you put aside money to fund your medical claims before meeting your deductible and save for future medical expenses. As an additional benefit, HealthEquity will provide 24/7 telephonic support and online information to help you better manage this account.

If you have selected a Coventry*One* QHDHP product and DO NOT want to take advantage of the HSA account, please check the "OPT-OUT" box below. Otherwise, you will receive a welcome kit and HSA debit card from HealthEquity, subject to this Coventry*One* QHDHP Application approval and acceptance.

☐ **OPT-OUT of having an HSA opened through HealthEquity**

Other Health Insurance Information

1. Is anyone applying for coverage in this Application covered by or eligible for coverage under Medicare? ☐ **Yes** ☐ **No**
   If yes, list the Applicants who are covered by or eligible for coverage under Medicare as of the requested effective date. **If so, this person(s) is not eligible for coverage**: _____
2. In the **PAST TEN (10) YEARS**, has anyone applying for coverage in this Application:
   A) Applied for Coventry Health Care of Georgia or any other Coventry Health Care plan? ☐ **Yes** ☐ **No**
   List the Applicants who have previously applied: _____
   B) Previously been enrolled in Coventry Health Care of Georgia or any other Coventry Health Care plan? ☐ **Yes** ☐ **No**
   List the Applicants who have been previously enrolled: _____
   C) Currently enrolled in Coventry Health Care of Georgia or any other Coventry Health Care plan? ☐ **Yes** ☐ **No**
   List the Applicants currently enrolled: _____
3. In the **PAST FIVE (5) YEARS**, has anyone applying for coverage in this Application had any form of life or health insurance denied, cancelled, postponed, had a waiver applied or been charged extra premium for life, disability or health insurance, or had such insurance rescinded or involuntarily terminated, restricted or rated up? ☐ **Yes** ☐ **No**

If yes, complete information below:

Applicant Name (Last, First, MI)	**Type of insurance** (circle)	**Name of company**	**Reason**
1.	Health / Life / Disability		
2.	Health / Life / Disability		
3.	Health / Life / Disability		

4. Is any person applying for coverage in this Application covered by any other health insurance? ☐ **Yes** ☐ **No**
   If no, skip to Lifestyle and Health History section. If yes, continue below:

Applicant Name (Last, First, MI)	**Name of Company**	**Type of coverage** (Group, Individual, COBRA, Short-Term, etc.)	**Replacing other coverage?**** (Circle one)	**If yes, anticipated Policy Term Date** (mm/dd/yyyy)
1.			☐ Yes ☐ No	
2.			☐ Yes ☐ No	
3.			☐ Yes ☐ No	

** Is the coverage being applied for in this Application intended to replace other carrier's coverage?
Anyone applying for coverage in this Application having other Coventry health coverage must cancel that other health coverage upon acceptance of Coventry*One* coverage, if offered. If other Coventry health coverage is not cancelled, this Coventry*One* coverage will be terminated as of the original effective date.
DO NOT cancel existing insurance coverage until notified in writing of approval of this Application by Coventry*One*.

THE FOLLOWING SECTION IS AN EXTREMELY IMPORTANT PART OF THIS APPLICATION AND REQUIRES YOUR CAREFUL TIME AND ATTENTION TO EACH AND EVERY QUESTION BELOW. YOUR FAILURE TO PROVIDE TRUTHFUL OR ACCURATE LIFESTYLE AND HEALTH HISTORY INFORMATION COULD RESULT IN A LOSS OF COVERAGE OR OTHER PENALTIES. WE RECOMMEND THAT YOU CONSULT YOUR PHYSICIAN IF YOU HAVE ANY QUESTIONS REGARDING THE INFORMATION BEING REQUESTED BELOW.

PLEASE NOTE THAT THE INFORMATION YOU ARE PROVIDING BELOW RELATES TO YOUR LIFESTYLE AND HEALTH HISTORY AND THE LIFESTYLE AND HEALTH HISTORY OF ANY OTHER PERSON APPLYING FOR COVERAGE UNDER THIS APPLICATION.

PLEASE NOTE THE ANSWERS TO THE QUESTIONS BELOW SHOULD BE ANSWERED BY YOU AND NOT BY AN AGENT OR BROKER REPRESENTING YOU.

Lifestyle and Health History

Check 'Yes' or 'No', when applicable. **Answer all questions completely**. Unanswered questions will delay or stop processing. Provide details in the Additional Information section. In order to process your Application, additional information may be required. A Coventry*One* representative may call you to discuss your Application. You may be asked to complete a questionnaire or to provide medical records. Failure to obtain the needed information will result in our inability to process the Application.

If the health status of any Applicant herein changes between the signature date of this Application and the latter of the coverage effective date or approval date, Coventry must be notified of the change in writing.

Lifestyle Questions

1. Is anyone listed in this Application (whether applying for coverage or not) currently pregnant, an expectant or surrogate parent, or in the process of adopting a child?	☐ Yes ☐ No
2. In the **PAST FIVE (5) YEARS**, has any person applying to be covered:	
A) Been advised to seek treatment for alcohol use or been advised to reduce alcohol intake, or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism?	☐ Yes ☐ No
B) Been a member of any alcohol or drug support group?	☐ Yes ☐ No
C) Used any illegal drugs or substances, or controlled substance not prescribed by a doctor, or been counseled for, diagnosed with, or treated for drug or chemical use or dependence (including prescription, non-prescription, or illegal)?	☐ Yes ☐ No
3. In the **PAST FIVE (5) YEARS**, has anyone applying for coverage in this Application been cited or convicted of driving under the influence of alcohol or any drug?	☐ Yes ☐ No
4. Within the **PAST TWELVE (12) MONTHS**, has any person to be covered consumed alcoholic beverages? (*Note: Even if only on occasion, please provide the number of drinks consumed on such occasions*.) Applicant Name _____Number drinks consumed per week: ☐ 0-7 ☐ 8-14 ☐ 15-20 ☐ 21-26 ☐ 27-35 ☐ 36+ Applicant Name _____Number drinks consumed per week: ☐ 0-7 ☐ 8-14 ☐ 15-20 ☐ 21-26 ☐ 27-35 ☐ 36+ Applicant Name _____Number drinks consumed per week: ☐ 0-7 ☐ 8-14 ☐ 15-20 ☐ 21-26 ☐ 27-35 ☐ 36+	☐ Yes ☐ No
5. Has anyone applying for coverage in this Application **EVER** been convicted of a felony, or been on, or is currently on probation? If yes, identify the person and details in the Additional Information section.	☐ Yes ☐ No

Lifestyle – Additional Information

Please explain and provide **FULL DETAILS** for each 'yes' answer to any of the preceding **Lifestyle** questions and **INDICATE TO WHICH APPLICANT THE INFORMATION APPLIES.** If additional space is needed, list on a separate sheet of paper and attach to this Application to include the signature and date signed by the Applicants.

Q #	Applicant Name (Last, First, MI)	Details of answer: Conditions, treatment, convictions, etc. (Indicate number of occurrences)	Start Date (mm/yyyy)	End Date (mm/yyyy)
Please check here if additional page is attached ☐				

Health Questions

6.	Within the **PAST TEN (10) YEARS**, has anyone applying for coverage in this Application had any signs or experienced symptoms that caused them or would cause an ordinary prudent person to seek advice, treatment or therapy, or consulted or sought medical treatment, been diagnosed, had medical treatment recommended, received medical treatment or therapy, been surgically treated, or been hospitalized for any of the following conditions:	
A)	Cancer**, including but not limited to**: melanoma, Hodgkin's disease, malignant sarcomas, carcinomas, tumors or cysts? If "Yes," provide location, type, stage, and treatment in the Additional Information Section.	☐ Yes ☐ No
B)	Heart attack, heart disease, stroke, aneurysm, multiple sclerosis, or hepatitis B or C; or been a candidate or a recipient of an organ or bone marrow transplant? If "Yes," specify which organ, and/or if bone marrow transplant in the Additional Information section.	☐ Yes ☐ No
C)	Had any implants (breast or penile), devices such as pacemakers, shunts, stents, valve replacements, monitoring devices or internal fixation devices (plates, pins or screws) or prosthetics? If breast implant, specify type: ☐ Silicone ☐ Saline	☐ Yes ☐ No
D)	Cardiovascular disorders, **including but not limited to**: hypertension, or high blood pressure, chest pain, heart murmur, mitral valve prolapse, palpitations or heart rhythm disturbance or surgery? If history of hypertension, high blood pressure or elevated blood pressure readings, provide three (3) blood pressure readings and dates, including the highest reading within the last **SIX (6) MONTHS.** These readings must have been taken by a physician. Date _____ Reading _____ Date _____ Reading _____ Date _____ Reading _____ Highest reading in **LAST SIX (6) MONTHS**: Date _____ Reading _____	☐ Yes ☐ No
E)	Blood disorders, **including but not limited to**: anemia, hemophilia, purpura, thrombocytopenia, leukemia, sickle cell anemia, abnormal white or red blood cells or abnormal bleeding?	☐ Yes ☐ No
F)	Vein or artery disorders, **including but not limited to**: phlebitis, thrombosis, varicose veins or ulcers, peripheral vascular disease or clots and poor circulation?	☐ Yes ☐ No
G)	Connective tissue disorders, **including but not limited to**: systemic (SLE) or discoid lupus, scleroderma, rheumatoid arthritis, CREST or Sjogren's syndromes?	☐ Yes ☐ No
H)	Cerebrovascular disorders, **including but not limited to**: stroke, transient ischemic attack (TIA), carotid bruits, or cerebral (brain) hemorrhage?	☐ Yes ☐ No
I)	Immune or lymph system disorders, **including but not limited to**: persistent lymph node enlargement, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV), persistent fever, persistent diarrhea, persistent fatigue, or weight loss of unknown cause?	☐ Yes ☐ No
J)	Nervous system disorders, **including but not limited to**: headaches, migraines, dizziness, epilepsy, fainting, tremors, convulsions, seizures, paralysis, autism, Alzheimer's, Parkinson's, amyotrophic lateral sclerosis (ALS) or cerebral palsy?	☐ Yes ☐ No
K)	Respiratory system disorders, **including but not limited to**: asthma, sinusitis, allergic rhinitis, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), dyspnea, tuberculosis, sarcoidosis or sleep apnea?	☐ Yes ☐ No
L)	Metabolic or endocrine disorders, **including but not limited to**: obesity, elevated lipids (cholesterol, triglycerides), diabetes or sugar intolerance; disorder of the thyroid, pituitary, adrenal, pancreas or other gland or goiter?	☐ Yes ☐ No
M)	Musculoskeletal disorders, **including but not limited to**: arthritis, fibromyalgia, gout, back, neck or spinal column disorders such as herniated disc(s); osteopenia/osteoporosis, ankylosing spondylitis, fractures, dislocations or disorders, polio/post-polio syndrome, muscular dystrophy, amputation, or persistent or recurring pain of the muscles, bones or joints or had spinal adjustments or manipulation therapy?	☐ Yes ☐ No
N)	Urinary tract disorders, **including but not limited to**: kidney or bladder stones, cystitis or other urinary tract infections, urethral stricture or stenosis, kidney transplant or dialysis, renal failure or polycystic kidney disease?	☐ Yes ☐ No
O)	Hernias, **including but not limited to**: inguinal, scrotal, hiatal (diaphragmatic) or umbilical?	☐ Yes ☐ No
P)	Female reproductive system disorders, **including but not limited to**: infertility, irregular menstruation, uterine fibroids, uterine prolapse, endometriosis, abnormal PAP smears, caesarian section or other complications of pregnancy? Date / results of most recent PAP smear: Date (mm/yyyy): _____ Results: _____ Date / results of first prior PAP smear: Date (mm/yyyy): _____ Results: _____	☐ Yes ☐ No
Q)	Ear, eye, nose, throat or skin disorders**, including but not limited to:** recurrent ear infections, Meniere's disease, deafness, blindness, cataracts, detached retina, glaucoma, optic atrophy, deviated nasal septum, nasal polyps, psoriasis, acne or skin tumors?	☐ Yes ☐ No
R)	Breast disorders, **including but not limited to:** breast cysts or tumors, fibrocystic breast disease, gynecomastia, mastitis or abnormal mammograms?	☐ Yes ☐ No

S)	Male reproductive disorders, **including but not limited to:** prostate disorder(s), elevated PSA testing, erectile dysfunction, infertility or male genital disorder?	☐ Yes ☐ No
T)	Mental or nervous disorders, **including but not limited to:** attention deficit disorder, anxiety, depression, eating disorders, bipolar disorder, schizophrenia or psychotic disorder?	☐ Yes ☐ No
U)	Intestinal or rectal disorders, **including but not limited to**: Crohn's disease, ulcerative colitis, intestinal polyps, hemorrhoids, irritable bowel syndrome (IBS), diverticulitis / diverticulosis?	☐ Yes ☐ No
V)	Sexually transmitted diseases, **including but not limited to**: gonorrhea, chlamydia, human papillomavirus (HPV), syphilis, genital warts or genital herpes?	☐ Yes ☐ No
W)	Digestive system disorders, **including but not limited to**: gastroesophageal reflux disease (GERD), esophageal stricture, esophageal varices, cirrhosis or other liver disorder, spleen disorder, stomach or duodenal ulcer(s), gallbladder disease or gall stones?	☐ Yes ☐ No
X)	Abnormal diagnostic tests, **including but not limited to:** abnormal blood tests, abnormal MRI or CT scan, x-ray, bone density, abnormal electrocardiogram (EKG) or echocardiogram?	☐ Yes ☐ No
7.	For situations/conditions not previously mentioned on this Application/Health Statement Form, within the **PAST FIVE (5) YEARS**, has any person applying for coverage in this Application:	
A)	Consulted or been examined or treated by any physician, chiropractor, psychologist, or other health care practitioner?	☐ Yes ☐ No
B)	Been to a clinic, hospital, emergency room, or other medical facility for treatment, confinement, or observation?	☐ Yes ☐ No
C)	Plan to, had, or been advised to have a procedure, tests or treatment that have not yet been performed?	☐ Yes ☐ No
D)	Had any disease, disorder, ailment, injury or condition not listed in this Application for which there have been, or are plans or intentions to seek advice, diagnosis, or treatment?	☐ Yes ☐ No

Health History – Additional Information

If any **health history** questions were answered with 'yes,' the following information must be completed. Please explain and provide **FULL DETAILS** for each 'yes' answer to any condition(s) checked in the preceding questions and **INDICATE TO WHICH APPLICANT THE INFORMATION APPLIES.** If additional space is needed, list on a separate sheet of paper and attach to this Application to include the signature and date signed by the Applicants.

Q #	**Applicant Name** (Last, First, MI)	**Conditions, treatment, operations** (Indicate number of occurrences)	**Date of onset** (mm/yyyy)	**Date of recovery** (mm/yyyy)	**Days in hospital**	**Last checkup for condition** (mm/yyyy)	**Results**	**Name, Address and Phone Number of Health Care Provider**
Please check here if additional page is attached ☐								

Applicant Name:_____ **Broker:**_____

Health Care Providers Seen in the Past Five (5) Years Not Listed Above

Applicant Name (Last, First, MI)	Name, Address and Phone Number of Health Care Provider	Details of Last Visit		
		Date (mm/yyyy)	Reason for Visit	Result (Circle one. If abnormal, explain.)
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
Please check here if additional page is attached ☐				

Prescription Medications and Injection Therapy

List all medications, including samples, and injection therapy taken or prescribed within the **PAST TWELVE (12) MONTHS** for any Applicant listed on this Application. Please include any over-the-counter (OTC) medications taken on a regular basis. If additional space is needed, list on a separate sheet of paper and attach to this Application to include the signature and date signed by the Applicants.

Applicant Name (Last, First, MI)	Medication / Dosage / Frequency (e.g., Lopressor™ / 100mg / daily)	Reason Prescribed / Taken	Date Prescribed (mm/dd/yyyy)	Still taking?	Date discontinued (mm/dd/yyyy)	Name, Address and Phone Number of Prescribing Physician
				☐ Yes ☐ No		
				☐ Yes ☐ No		
				☐ Yes ☐ No		
				☐ Yes ☐ No		
				☐ Yes ☐ No		
Please check here if additional page is attached ☐						

Broker Information

The following sections are to be completed by the broker.

Broker Name:	Broker ID #:	Broker Email Address:
Broker Signature:	Agency Name:	Broker/Agency Phone: ( )

PRODUCER CERTIFICATION

I am not aware of any other information which may have a bearing on the insurability of anyone to be covered and have not altered any responses recorded on this Application or any supplement to it. I have not advised the Applicant to withhold any information regarding the answers to the questions and have advised the Applicant to review the Application and the answers recorded to confirm completeness and accuracy. I further attest that all answers recorded above are correct, complete, and wholly true to the best of my knowledge and belief.

Producer Signature _____ **Date**_____

- Please keep a copy of the completed, signed application for your files.

Conditions of Enrollment

I represent that all information on this Application form is complete and accurate and true to the best of my knowledge. I understand that my answers to the questions on this form will be used as the basis to determine eligibility for coverage. I further understand that if any information is omitted or intentionally misrepresented, it could provide the basis to refuse, reform or rescind coverage and to adjust as applicable, or refund any premiums paid as though coverage had never been in force. After coverage has been in force for two years, no statement except fraudulent statements I make voids my coverage or reduces my benefits. I understand that if my Application for coverage is declined, I may not apply for Coventry*One* coverage for **SIX (6) MONTHS**. I understand that if my health changes or any of the answers or statements provided herein change between the signature date of this Application and the latter of the coverage effective date or approval date, I must inform Coventry*One* of such change in writing. I understand that failure to do so may result in the denial, reformation or rescission of coverage.

I understand and acknowledge that the selling agent, if applicable to this Application for coverage, has no authority to promise coverage to Applicants herein or to modify Coventry*One* underwriting policy or the terms of Coventry coverage.

ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT STATEMENT OR REPRESENTATION OF ANY MATERIAL FACT OR THING IN THE FILING OF A CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE COMMITS THE CRIME OF INSURANCE FRAUD, WHICH IS A FELONY, AND WILL BE PUNISHED BY IMPRISONMENT, OR BY FINE, OR BOTH.

THE EFFECTIVE DATE OF COVERAGE OF APPLICANTS LISTED HEREIN IS ASSIGNED BY COVENTRY AT ITS DISCRETION, SUBJECT TO MEDICAL UNDERWRITING; AND AN OFFER OF COVERAGE AND PREMIUM AMOUNT BEING PRESENTED AND ACCEPTED.

DO NOT CANCEL EXISTING INSURANCE COVERAGE UNTIL NOTIFIED IN WRITING BY COVENTRY OF APPLICATION APPROVAL.

ACKNOWLEDGEMENT

I understand I am enrolling in a health care plan which 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 I receive, and I will be fully responsible for any and all costs not covered by Coventry. I understand that my Individual Member Contract provides additional details explaining the use of participating and non-participating providers under the plan.

I have received instructions on how to obtain a list of the participating providers. I understand that a provider's participating 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's website at www.chcga.com, which 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 provides the following summary of financial arrangements with the health care providers who are participating in the Coventry network:

(a) Hospitals are paid according to a contract that includes inpatient per diems, case rates and discounted fee for service arrangements depending on the specific service provided.

(b) Physicians are paid through capitation or discounted fee for service in accordance with a specific fee schedule which has been provided to them as contracted.

(c) 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.

PRIMARY APPLICANT SIGNATURE	DATE	**SPOUSE SIGNATURE** (If applying for coverage)	DATE
DEPENDENT APPLICANT SIGNATURE*	DATE	**DEPENDENT APPLICANT SIGNATURE***	DATE

*Required age 18 and over.

If minor child-only application (under the age of 18), this section must be signed by the minor child's (children's) parent or legal guardian identified in the Applicant and Dependent Information Section.

PARENT / LEGAL GUARDIAN SIGNATURE	**PRINT NAME**	**RELATIONSHIP TO APPLICANT**	**DATE**

- Please keep a copy of the completed, signed application for your files.

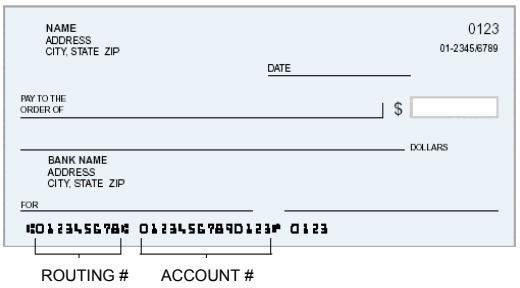
Applicant Name:_____ **Broker:**_____

Premium Payment

Premiums due for coverage under a policy pursuant to the approval of this Application and acceptance of coverage will be paid from funds automatically deducted from either a checking or savings account, upon the Account Holder's authorization herein, subject to the Coventry approval of this Application and the acceptance of an offer coverage. To facilitate the premium withdrawal this section must be completed in its entirety. This payment information does not guarantee approval or coverage.

Premiums due for coverage may be facilitated by non-automated account deduction. When non-automated account deduction is selected, a check or money order for the initial premium amount due must accompany this Application. Premium is due on the 1st of the month thereafter, regardless of whether a monthly statement is received. A $5.00 monthly administrative fee is assessed for this service and is due with the premium payment. The Account Holder may opt to switch to premium payment by automatic withdrawal at anytime during the course of the policy period. Election to shift from automatic withdrawal to non-automated account deduction is permitted once per policy period, or upon renewal. To shift payment method, contact Coventry.

Please Provide: ☐ Checking Account ☐ Savings Account



Name of Bank or Savings Institution: _____

9-Digit Routing Number: 1___1___1___1___1___1___1___1___1___1

Account Number: _____ _____
(A voided check or savings account deposit slip should be attached in support of content in this section)

Name of Account Holder: _____

Relationship of Account Holder to the Primary Applicant: ☐ Self ☐ Spouse ☐ Other _____

Permanent Address of Account Holder: _____

_____

NOTE: If banking information is from a business account, or you are submitting a check drawn from a business account, please contact your agent to complete a Coventry*One* Payroll Deduction Authorization Form.

Applicable Premium amount is automatically withdrawn from the account provided herein on the 10th day of each current coverage month, or the next business day. The initial premium withdrawal may not occur until the 10th of the month following the first month of coverage and will account for the total amount owed from the original effective date. For example, if the first months' premium is calculated beginning on the 15th of the month but not withdrawn until the 2nd month of coverage, the amount due in the 2nd month will equal one and one half (1½) the total monthly premium amount. If the first months' premium is calculated beginning on the 1st of the month but not withdrawn until the 2nd month of coverage, the amount due in the 2nd month will be twice the total monthly premium amount.

If premium payment is returned unpaid, a Return Check Fee amount will be assessed in the amount of $20.00. Account Holder hereby authorizes Coventry to collect the premium payment due on the 20th of the month, or next business day, including the Return Check Fee amount, via electronic funds transfer (EFT) or automatic withdrawal from the account identified and provided herein or then current.

By signing below, I authorize Coventry to initiate automatic withdrawal of applicable premium payments from the account listed above.

I, the Account Holder, acknowledge and understand that it is my responsibility to notify Coventry should the payment information provided herein change while a policy of coverage pursuant to this Application remains in force and effect.

Account Holder Signature:_____ **Date:**_____

- Please keep a copy of the completed, signed application for your files.

Applicant Name:_____ **Broker:**_____

Authorization of Release of Information

I, for myself and any of my Dependents who are under the age of 18 who and are applying for coverage hereunder, hereby make the following authorizations:

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, insurance company, claims administrator, employer, governmental agency or other person or firm, to disclose to Coventry or its authorized representatives, my (or my Dependents') personal information, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to me, including without limitation, information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or the use of drugs or alcohol. I also authorize the release of information relating to mental illness.

In addition, I authorize Coventry to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by Coventry for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for Coventry to consider my Application and to determine whether or not an offer of coverage will be made. No action will be taken on my Application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by Coventry as permitted or required by law and may no longer be protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request.

I authorize Coventry to use or disclose the information I provide in this Application (or that the Coventry has or receives from third parties) for purposes of administering my health insurance benefits. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) or such shorter period required by law. Any revocation will not affect the activities of Coventry prior to the date such revocation is received by Coventry.

PRIMARY APPLICANT SIGNATURE	DATE	**SPOUSE SIGNATURE** (If applying for coverage)	DATE
DEPENDENT APPLICANT SIGNATURE*	DATE	**DEPENDENT APPLICANT SIGNATURE***	DATE

*Required age 18 and over.

If minor child-only application (under the age of 18), this section must be signed by the minor child's (children's) parent or legal guardian identified in the Applicant and Dependent Information Section.

PARENT / LEGAL GUARDIAN SIGNATURE	**PRINT NAME**	**RELATIONSHIP TO APPLICANT**	**DATE**

- Please keep a copy of the completed, signed application for your files.