

Application Submission Instructions

**Please complete the attached application and send to HealthPlanOne either via fax or mail:
(must submit by mail if enclosing a check or money order)**

**HealthPlanOne
35 Nutmeg Drive, Suite 220
Trumbull, CT 06611**

Fax (Toll Free): 888.812.6887

Please make check payable to the carrier to which you are applying.

Any questions? Please call HealthPlanOne at 1-877.567.5267. Thank you!

Application for Coventry Individual Health Insurance

Products are underwritten by Coventry Health and Life Insurance Company

Primary Applicant's Name

Applicant's Social Security Number

INSTRUCTIONS:

- Complete in blue or black ink only.
- PRINT clearly.
- All answers must be complete and truthful.

IMPORTANT NOTES:

- The information you provide is confidential.
- Intentional misrepresentation may result in the policy being modified or terminated.
- Proof of state residency may be required.
- **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	County	
Relationship (If Child-Only Application)				
Mailing Address (If different from your Home address)				
City			State	ZIP Code
E-mail Address				
Telephone Number		If we need to call you with questions about your application, when is the best time to reach you?		
Home	()	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
Work	()			
Mobile	()			

Section B – Application Type

Application Type (Select one):	
<input type="checkbox"/> New medical coverage	<input type="checkbox"/> Child-Only Application (Children up to age 21)
<input type="checkbox"/> Change current coverage	<input type="checkbox"/> Add dependent(s) to current coverage
Your Effective Date will be assigned by Coventry, based on the receipt date of your application.	

Primary Applicant's Name

Section C – Enrollment Period

- Annual Open Enrollment Period** (Annual period to enroll in medical coverage if no Special Enrollment Period applies. If you qualify for a Special Enrollment Period during the Annual Open Enrollment Period, coverage may start sooner.)
- Special Enrollment Period** (If you qualify for a Special Enrollment Period, you can enroll in medical coverage outside the Annual Open Enrollment Period. If you qualify for a Special Enrollment Period during the Annual Open Enrollment Period, coverage may start sooner.)

If one of the events listed below applies to you, check the appropriate box.

The Special Open Enrollment Period for the following events begins 60 days prior to the date of the event checked and continues for 60 days after.

Date of Event	Event
_____	<input type="checkbox"/> Loss of employer coverage due to termination of employment, reduction in hours, coverage no longer offered to my employment class, or expiration of COBRA coverage.
_____	<input type="checkbox"/> Loss of employer or individual coverage because no longer eligible as a dependent.
_____	<input type="checkbox"/> Loss of employer or individual coverage because of divorce from policyholder, death of policyholder, or policyholder enrolled in Medicare.
_____	<input type="checkbox"/> Loss of Medicaid or CHIP coverage.
_____	<input type="checkbox"/> Coverage needed following loss of eligibility for Exchange subsidies.
_____	<input type="checkbox"/> A permanent move.

The Special Open Enrollment Period for the following events begins on the date of the event checked and continues for 60 days.

_____	<input type="checkbox"/> Coverage needed for new dependent through marriage.
_____	<input type="checkbox"/> Coverage needed for new dependent through birth, adoption or placement for adoption.
_____	<input type="checkbox"/> Other, please explain. _____

Section D – Coverage Selection

Choose the plan that best meets your needs.
 Carelink from Coventry PPO and FocusedCare HPN PPO plans utilize a limited provider network. If you wish to indicate a Primary Care Physician (PCP), please indicate it under the Persons Requesting Coverage section. You may consult the health plan’s website www.coventryone.com for a listing of participating providers.

Bronze:	Silver:	Gold:
PPO Plans		
<input type="checkbox"/> Coventry Bronze \$30 Copay PD	<input type="checkbox"/> Coventry Silver \$15 Copay PD	<input type="checkbox"/> Coventry Gold \$15 Copay PD
<input type="checkbox"/> Coventry Bronze Deductible Only HSA Eligible PD		
Carelink from Coventry PPO Plans		
<input type="checkbox"/> Coventry Bronze \$25 Copay Carelink PD	<input type="checkbox"/> Coventry Silver \$10 Copay Carelink PD	<input type="checkbox"/> Coventry Gold \$10 Copay Carelink PD
<input type="checkbox"/> Coventry Bronze Deductible Only HSA Eligible Carelink PD		
FocusedCare HPN PPO Plans		
<input type="checkbox"/> Coventry Bronze \$30 Copay FocusedCare HPN PD	<input type="checkbox"/> Coventry Silver \$15 Copay FocusedCare HPN PD	<input type="checkbox"/> Coventry Gold \$15 Copay FocusedCare HPN PD
<input type="checkbox"/> Coventry Bronze Ded Only HSA Eligible FocusedCare HPN PD		

Health Savings Account (HSA) If you have selected an HSA Eligible 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.

Primary Applicant's Name

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 you need more space 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 six (6) months, check "Yes" as Tobacco User below (This does not apply to applicants under the age of 18). Regular use means an average of four or more times per week.

If any person uses tobacco for religious or ceremonial purposes only, check "No" for Tobacco User below.

If choosing a Carelink from Coventry or FocusedCare HPN product and wish to indicate a Primary Care Physician (PCP), please enter the PCP name and ID Number below. Primary Care Physician (PCP) refers to the provider that you would see first for any medical problem. The PCP must be within our provider network. A list of participating providers can be found at www.coventryone.com by selecting the Find a Doctor link. Please note that choice of PCP is not guaranteed; however, you can change your PCP at any time.

Primary Applicant Name (Last, First, Middle Initial)				Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco User <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP Name _____ PCP ID Number _____
Spouse/Domestic Partner Name (Last, First, Middle Initial)				Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco User <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP Name _____ PCP ID Number _____
Child 1 Name (Last, First, Middle Initial)				Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco User <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP Name _____ PCP ID Number _____
Child 2 Name (Last, First, Middle Initial)				Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco User <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP Name _____ PCP ID Number _____
Child 3 Name (Last, First, Middle Initial)				Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco User <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP Name _____ PCP ID Number _____

continued

Primary Applicant's Name

Section E – Persons Requesting Coverage (Continued)

Form for Child 4 and Child 5 information, including Name, Social Security Number, Date of Birth, Age, Gender, Tobacco User, PCP Name, and PCP ID Number.

To be completed by the Primary Applicant

Main form for primary applicant completion, including Marital Status, residency questions, insurance coverage, communication preferences, Medicare enrollment, citizenship, and proof of state residency.

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 pay a fee to a third party for certain protected health information (PHI) about me, including but not limited to, prescribed medication history or other pharmaceutical information, hospital records, physician and/or dentist records, claims or benefit records or lab results. The PHI purchased by Coventry may be used for the following purposes: a) to coordinate medical care and case management, and/or b) for risk adjustment activities.

PHI purchased by Coventry may be related to chronic diseases, mental illness, alcohol or substance abuse, Human Immunodeficiency Virus (HIV) infection, or Acquired Immune Deficiency Syndrome (AIDS).

I authorize Coventry to disclose my PHI for the purposes stated above to other persons or organizations performing services on Coventry's behalf. 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 written notice to Coventry using the address provided in Section J. 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)

Recurring or Follow Up Payments

Electronic Fund Transfer (complete the EFT information below)

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.

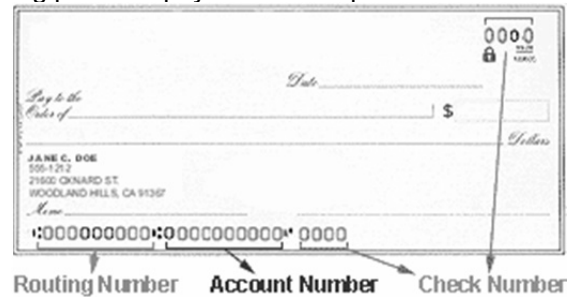
Account Number: _____

Routing Number:

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: CoventryOne 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 CoventryOne 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 CoventryOne 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 within 60 days of the receipt of this application.
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.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Special Missouri Notice: An enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical or religious beliefs. This Individual Plan does not have an optional rider for elective abortions purchased by the group contract holder pursuant to VAMS section 376.805.

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 WILLIAM C. STAPLETON	NPN of Agent 8577379
Signature of Producer (required if applicable)	Telephone Number (888) 567-5267
E-mail Address SALES@HEALTHPLANONE.COM	Fax Number (888) 812-6887
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) 35 NUTMEG DRIVE SUITE 220 TRUMBULL, CT 06611	

Complete if Broker of Record is an Agency

Name of Agency HEALTHPLANONE, LLC	TIN of Agency 20-4098658	
E-mail Address SALES@HEALTHPLANONE.COM	Telephone Number (888) 567-5267	Fax Number (888) 812-6887
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) 35 NUTMEG DRIVE SUITE 220 TRUMBULL, CT 06611		
Print Name of Producer Representing Agency	NPN Number 8577379	
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	Fax #: 877-904-7822
PO Box 31217	E-mail: cvtynewapps@healthplan.com
Tampa, FL 33631-3217	Website for information: www.coventryone.com