

Employee Enrollment / Change Form

Administered by

Coventry Healthcare Management Corporation

* 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	
<input type="checkbox"/> New Group <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change <input type="checkbox"/> Waive	
*Company Name: _____	*Group No.: _____
Date Employed Full Time: _____ / _____ / _____	*Effective Date of Coverage or Change: _____ / _____ / _____
**REASON FOR ENROLLMENT <input type="checkbox"/> New Group: <input type="checkbox"/> New Hire: <input type="checkbox"/> COBRA: <input type="checkbox"/> Retired: <input type="checkbox"/> Open Enrollment: <input type="checkbox"/> Qualifying Event (Reason): Date _____ / _____ / _____	
**REASON FOR CHANGE: (Please check all that apply and include supporting documentation.) <input type="checkbox"/> Enroll Dependent <input type="checkbox"/> Terminate Dependent <input type="checkbox"/> Terminate Subscriber <input type="checkbox"/> Name Change (Previous Name) <input type="checkbox"/> Address/Phone Termination Reason: <input type="checkbox"/> Group Request <input type="checkbox"/> Member Request <input type="checkbox"/> Deceased	
EMPLOYEE STATUS: <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Salary <input type="checkbox"/> Hourly (Number of hours a week _____) <input type="checkbox"/> Other _____	
Benefits Administrator Approval: _____	Date: _____

B SUBSCRIBER INFORMATION	
I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS: <input type="checkbox"/> None / Waive (please complete section F)	
<input type="checkbox"/> PPO <input type="checkbox"/> OOA <input type="checkbox"/> QHDHP	
Type of Coverage: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Children <input type="checkbox"/> Family	
*Last Name _____	*First Name _____ MI _____
*Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	*Birthdate: _____ / _____ / _____
*Address: _____	
*City: _____	*State: _____ *Zip Code: _____
Email Address: _____	
Height: _____ Weight: _____	Marital Status (please check one.) <input type="checkbox"/> Single/Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
Work Phone: _____ - _____ - _____	Home Phone: _____ - _____ - _____

C FAMILY MEMBERS TO BE COVERED OR DELETED	
<input type="checkbox"/> Add <input type="checkbox"/> Delete	
*Last Name _____	*First Name _____ MI _____
*Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	*Relationship <input type="checkbox"/> Child <input type="checkbox"/> Other
Student/Disabled <input type="checkbox"/> Student <input type="checkbox"/> Disabled	*Birthdate: _____ / _____ / _____
Height: _____ Weight: _____	Social Security Number: _____ - _____ - _____
<input type="checkbox"/> Add <input type="checkbox"/> Delete	
*Last Name _____	*First Name _____ MI _____
*Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	*Relationship <input type="checkbox"/> Child <input type="checkbox"/> Other
Student/Disabled <input type="checkbox"/> Student <input type="checkbox"/> Disabled	*Birthdate: _____ / _____ / _____
Height: _____ Weight: _____	Social Security Number: _____ - _____ - _____

Applicant Name: _____

<input type="checkbox"/> Add <input type="checkbox"/> Delete	*Last Name	*First Name	MI
*Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	*Relationship <input type="checkbox"/> Child <input type="checkbox"/> Other	Student / Disabled <input type="checkbox"/> Student <input type="checkbox"/> Disabled	*Birthdate
			Social Security Number
		Height	Weight

D OTHER MEDICAL AND/OR PHARMACY COVERAGE INFORMATION

When coverage with Builders Benefits 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 Prescription Drug Medicaid TRICARE Other _____

Other Insurance Company Name	Policy Holder Name	Covered Dependents
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Birthdate
		Effective Date of Other Insurance
Other Insurance Company Name	Policy Holder Name	Covered Dependents
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Birthdate
		Effective Date of Other Insurance

Medicare Information

<input type="checkbox"/> Subscriber or <input type="checkbox"/> Dependent	Dependent's Last Name	Reason for Medicare Eligibility
Effective Date Of:		<input type="checkbox"/> Over 65
Part A	Dependent's First Name	<input type="checkbox"/> Disabled
Part B		<input type="checkbox"/> Kidney Disease (ESRD)
Part D	Medicare #	<input type="checkbox"/> ALS (Lou Gehrig's Disease)
<input type="checkbox"/> Subscriber or <input type="checkbox"/> Dependent	Dependent's Last Name	Reason for Medicare Eligibility
Effective Date Of:		<input type="checkbox"/> Over 65
Part A	Dependent's First Name	<input type="checkbox"/> Disabled
Part B		<input type="checkbox"/> Kidney Disease (ESRD)
Part D	Medicare #	<input type="checkbox"/> ALS (Lou Gehrig's Disease)

Applicant Name: _____

E HEALTH INFORMATION

(Please answer each question fully and accurately. Incomplete answers could delay the processing of your requested coverage.)
 Health history of you and your family (include information about family members you wish to cover) - Has any person listed on this application ever consulted for, sought treatment, had treatment recommended, received treatment, been surgically treated, or been hospitalized for any of the following conditions: Please answer Yes or No.

1) Has any person listed on this application been hospitalized for any medical condition, chemical or substance abuse problem in the past two years? Yes No

2) Is any female to be covered under this policy currently pregnant? If currently pregnant, have you had complications with current or past pregnancies? (Please provide due date and details below) Yes No

3) Have you or any family member (including those not covered on this policy) ever been treated for the following?			Still under treatment?	Date ended
• Any cancer (including Hodgkin's or Leukemia)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
• Hemophilla	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
• Multiple Sclerosis / ALS (Lou Gehrig's)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
• Rheumatoid Arthritis or other connective tissue disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
• Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
• Any immune deficiency disorder HIV / AIDS or AIDS Related Complex (ARC)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
• Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
• Lyme Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
• Chronic back or disc problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
• Coronary artery disease / Angioplasty / CABG or stents	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
• Are you being treated for any condition not listed above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

If you answered yes to question 1, 2, or 3 or have any medical conditions not listed above please provide full details of treatment.

4) Please list any over the counter (OTC) drugs, prescription drugs and/or injectable medications you or your family members are regularly taking or are supposed to be taking.

Employee/Dependent Name	Diagnosis	Drug Name	OTC Yes/No	Dosage	Frequency of Dose

Please use additional paper if necessary.

F 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 change in status as defined in the Plan Document and Summary Plan Description.

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

G 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 20 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 Preferred Provider Organization (PPO) and Prescription coverage. I understand if I or one of my dependents receive medically necessary covered services from a non-participating provider, Builders Benefits will only cover the lower level benefits set forth in the applicable group contract/Employer Group Enrollment Form and I will be responsible for payment of any amount not covered by Builders Benefits. 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 Builders Benefits 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.

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.

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

Applicant Signature _____ Date _____

Applicant Printed Name _____

GENERAL PROVISIONS

For members enrolled in Builders Benefits in-area and out-of-area plans, products are underwritten by Builders Benefits. If you have any questions about which product you are enrolling in, call our member services at 1-866-761-7448.

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 Plan Document and Summary Plan Description which outlines in detail Builders Benefit's Member Complaint and Appeals Procedure.

If address and phone numbers of covered dependents are different from that of policyholder, please attach that information on a separate sheet of paper.