



Employee Enrollment/Waiver of Coverage/ Health Statement Form

Insurer's Use Only: Group No.:										
A. Employee Information										
Last Name	First Name	MI	Home Phone () ()		County		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married			
Address	City	State	Zip	Work Phone () ()						
Group/Employer Name	Occupation	Hire Date	Salary/Year \$							
B. Waiver of Coverage (If waiving coverage, please complete this section, skip sections C and D, then sign and date the back of this form.)										
I Waive Medical Coverage for: Reason waiving coverage: <input type="checkbox"/> Myself (Employee) & Any Eligible Dependents <input type="checkbox"/> Covered by other group medical insurance. List insurer: _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Other reason (please explain): _____										
If you are waiving/declining medical coverage for yourself or your dependents (including your spouse) because of other medical coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within 31 days after your coverage ends. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after a marriage, birth, adoption or placement for adoption. If you are waiving medical coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period and a preexisting condition exclusion period may apply.										
C. Coverage Selection and Member Information										
Coverage for: <input type="checkbox"/> Employee Only <input type="checkbox"/> EE + Spouse <input type="checkbox"/> EE + Child(ren) <input type="checkbox"/> EE + Family <input type="checkbox"/> COBRA / Continuation (Original Starting Date: _____)										
Plan type: <input type="checkbox"/> HMO: _____ <input type="checkbox"/> POS: _____ <input type="checkbox"/> PPO: _____										
Employee	Last Name, First Name, MI	Gender	Birth date	Height	Weight	Social Security Number	List Other Medical Insurance Coverage (If none, please mark "N/A")	Dependent Status	Out of Service Area*	Resides with Subscriber*
Employee		<input type="checkbox"/> M <input type="checkbox"/> F					Insurer: _____ Coverage Continues?: <input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	N/A	N/A
Spouse		<input type="checkbox"/> M <input type="checkbox"/> F					Insurer: _____ Coverage Continues?: <input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> N
Child		<input type="checkbox"/> M <input type="checkbox"/> F					Insurer: _____ Coverage Continues?: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Student <input type="checkbox"/> Disabled	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> N
Child		<input type="checkbox"/> M <input type="checkbox"/> F					Insurer: _____ Coverage Continues?: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Student <input type="checkbox"/> Disabled	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> N
Child		<input type="checkbox"/> M <input type="checkbox"/> F					Insurer: _____ Coverage Continues?: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Student <input type="checkbox"/> Disabled	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> N
Child		<input type="checkbox"/> M <input type="checkbox"/> F					Insurer: _____ Coverage Continues?: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Student <input type="checkbox"/> Disabled	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> N
Child		<input type="checkbox"/> M <input type="checkbox"/> F					Insurer: _____ Coverage Continues?: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Student <input type="checkbox"/> Disabled	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> O <input type="checkbox"/> N

* Coverage will not be offered to dependents living outside of the service area, unless they are a qualified Full-Time Student, or if coverage is required by a court decree. If you are subject to a court decree to provide health insurance coverage for any of the dependents listed above, please provide a copy of the decree. For disabled dependents, please provide a written description and proof of disability.

D. Health Information – used for rating purposes only.

Please answer each question fully and accurately for yourself and your dependent(s) unless you are waiving all coverage. You must give full details for all "Yes" questions in space provided below. If necessary, please date and sign any additional pages. Incomplete answers could delay the decision on your request for coverage.

1. Is anyone currently taking medication or receiving any medical treatment of any kind? List below.	<input type="checkbox"/> Y <input type="checkbox"/> N	4. Has anyone smoked cigarettes or used tobacco products within the past 12 months?	<input type="checkbox"/> Y <input type="checkbox"/> N
2. Within the past 5 years, have you or your dependents been advised to have surgery, treatment or tests not yet performed?	<input type="checkbox"/> Y <input type="checkbox"/> N	5. Are you or any family member pregnant? (Indicate expected delivery date and any complications.)	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Has anyone been to the emergency room or hospitalized within the past 5 years?	<input type="checkbox"/> Y <input type="checkbox"/> N	Due date:	

Has anyone within the past 10 years, had any diagnosis or treatment for any of the following:

6. Chest pain or pressure, heart trouble, heart attack, heart murmur, rapid, slow or irregular heart beat?	<input type="checkbox"/> Y <input type="checkbox"/> N	15. Mental or nervous disorders (including emotional or behavioral disorders)?	<input type="checkbox"/> Y <input type="checkbox"/> N
7. High blood pressure, stroke or other circulatory problems?	<input type="checkbox"/> Y <input type="checkbox"/> N	16. Cancer, tumors, cysts, polyps or growths of any kind?	<input type="checkbox"/> Y <input type="checkbox"/> N
8. Epilepsy, seizures, convulsions or frequent headaches?	<input type="checkbox"/> Y <input type="checkbox"/> N	17. Rashes or any other skin condition?	<input type="checkbox"/> Y <input type="checkbox"/> N
9. Pancreas, liver, spleen or gallbladder problems?	<input type="checkbox"/> Y <input type="checkbox"/> N	18. Disease or disorder of the eyes, ears, nose, mouth, throat, or sinuses?	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Prostate, kidney or bladder problems, or blood in the urine?	<input type="checkbox"/> Y <input type="checkbox"/> N	19. Back, neck or spinal problems; bone, jaw or muscle condition?	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Any male or female reproductive organs, menstruation problems, abnormal pap test?	<input type="checkbox"/> Y <input type="checkbox"/> N	20. Arthritis, gout or joint disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Venereal disease (such as gonorrhea, syphilis, genital herpes, chlamydia) or other infectious disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	21. Blood disorders; diabetes, or disease or disorder of the thyroid, breast or other glands?	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Bronchitis, tuberculosis, asthma, emphysema, pneumonia, or other respiratory or lung problems?	<input type="checkbox"/> Y <input type="checkbox"/> N	22. Alcohol or drug problem, dependency, abuse, overdose or drug reaction?	<input type="checkbox"/> Y <input type="checkbox"/> N
14. Chiron's disease, ulcers, colitis, intestinal disorders, hemorrhoids, proctitis, hernia, other digestive problems?	<input type="checkbox"/> Y <input type="checkbox"/> N	23. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the HIV virus?	<input type="checkbox"/> Y <input type="checkbox"/> N

Please give full details for all "Yes" questions (above). If necessary, attach additional pages. Please date and sign any additional pages.

Question #	Covered Person's Name	Diagnosis and Dates of Treatment	Medications	Doctor's Name

Agreement and Authorization

Unless waiving coverage as listed in Section B, by signing this form, I am applying for covered services for which my family and I are eligible and I authorize my employer to deduct from my earnings any required contributions.

I agree on behalf of myself and those family members enrolled ("Dependents"), for whom I have the authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as my "Enrolled Family"), that Coventry Health Care of Kansas, Inc., Coventry Health and Life Insurance Company or their authorized representatives (collectively referred to as "Health Plan") may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering my health insurance benefit, including for treatment, payment or health care operations, as those terms are explained in detail in Health Plan's Notice of Privacy Practices and to the extent permitted by law.

I also agree on behalf of myself and my Dependents, that, to the extent permitted by law, health care providers, insurers, claims administrators, employers and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, autoimmune deficiency syndrome, AIDS related complex, human immunodeficiency virus or genetic conditions to Health Plan for Health Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law.

I represent the information to be complete and accurate to the best of my knowledge. I understand that my answers to the questions on this form, except for those questions in Section D, will be used to determine eligibility for coverage. I further understand that if any information is omitted or misrepresented, it could provide the basis to refuse or rescind coverage and to 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.

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.

I have read and agree to the statements above.

Employee Signature	Employee Printed Name	Date
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INCOMPLETE FORMS WILL BE RETURNED, DELAYING ELIGIBILITY, CLAIMS PROCESSING, RECEIPT OF ID CARDS(S) AND MAY RESULT IN DENIED CLAIMS