



Enrollment/Health Statement Form

Groups 1-25 Employees



A SUBSCRIBER INFORMATION (To Be Completed by Employee)

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS:

WellPath Select, Inc.(WP) Coventry Health and Life Insurance Company (CHL)
 HMO _____ POS _____ PPO _____

PLEASE MAKE THE FOLLOWING CHANGES: **Please include supporting documentation for the change.**

ENROLL	CHANGE	TERMINATE COVERAGE
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Add Dependent (reason for addition) _____	<input type="checkbox"/> Cancel Coverage (reason) _____
<input type="checkbox"/> New Hire (date of hire) _____	<input type="checkbox"/> Delete Dependent (reason for deletion) _____	<input type="checkbox"/> Last Date of Employment _____
<input type="checkbox"/> COBRA (date of eligibility) _____	<input type="checkbox"/> Name Change (previous name) _____	
<input type="checkbox"/> Qualifying Event (description/date) _____	<input type="checkbox"/> Address Change _____	

Pre-existing conditions exclusion period is 12 months for timely enrollees and 18 months for late enrollees unless you provide proof of coverage (Certificate of Creditable Coverage) from your prior plan(s).

LAST NAME	FIRST NAME	MI	M/F	BIRTHDATE	HEIGHT/ WEIGHT	SOCIAL SECURITY NO.	EMPLOYMENT STATUS Please check one:
							<input type="checkbox"/> ACTIVE HIRE DATE _____
ADDRESS							<input type="checkbox"/> RETIRED
E-MAIL ADDRESS							<input type="checkbox"/> TERMINATED Dept. _____
CITY	STATE	ZIP	HOME PHONE		WORK/DAY PHONE		MARITAL STATUS Please check one:
							<input type="checkbox"/> SINGLE/WIDOWED
							<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED

B FAMILY MEMBERS TO BE COVERED OR DELETED

ENROLL OR DELETE	FULL NAME (LAST, FIRST, MI)	HEIGHT/ WEIGHT	SEX	RELATIONSHIP	BIRTHDATE	COLLEGE STUDENT	SOCIAL SECURITY #
E D			M F	SPOUSE	/ /		- -
E D			M F		/ /	Y N	- -
E D			M F		/ /	Y N	- -
E D			M F		/ /	Y N	- -
E D			M F		/ /	Y N	- -

C OTHER INSURANCE Do you or your dependents have other coverage? No _____ If Yes, complete the following:

List all covered family members with medical health insurance in addition to WellPath Select, Inc. (WP) or Coventry Health and Life Insurance Company (CHL).

POLICY HOLDER	BIRTHDATE	EMPLOYER	INSURANCE COMPANY
LIST DEPENDENTS COVERED		EFFECTIVE DATE	CONTRACT NO./GROUP NO.
Do you or your covered dependents have Medicare Coverage? _____ Yes _____ No If Yes, please complete the following and note why you or your dependents have Medicare coverage. If due to End Stage Renal Disease, what was the first date of dialysis?: _____			
NAME (Medicare Beneficiary)	MEDICARE ID NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE
Actively Working? Y N			

D EMPLOYER INFORMATION (To be completed by employer.)

Group No.	Group Name	Effective Date	Employer's Signature	Date
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E HEALTH INFORMATION (Please answer completely. Incomplete answers could delay the decision on your request for coverage. When answer is "Yes", please circle the condition.)

Please answer each question fully and accurately for yourself and your dependent(s) unless you are waiving all coverage.

Please give full details for all "Yes" questions in the space provided below. Additional pages may be used but must be signed and dated.

- | | | |
|---|----------------------------|----------------------------|
| 1. Epilepsy, stroke, or paralysis? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Head or spinal injuries, muscular dystrophy, cerebral palsy or multiple sclerosis?
Neck or back pain, chiropractic visits, or disorder of the spine, discs or back? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Migraines? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Blood disorders or sickle cell? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Bladder, kidney, prostate, kidney failure, uterine, testicular, or breast problems? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 6. Vascular disease? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. Colitis, diverticulosis, ulcers, gall bladder, hernias, rectum disorders or Crohn's? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 8. Asthma, allergies, or hay fever? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 9. Emphysema, tuberculosis, or lung disorders? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 10. Diabetes? Type I or II (Please give full details below.) | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 11. Thyroid, hormonal, or glandular disorder? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 12. Cigarette or tobacco use? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, how many per day? _____ | | |
| 13. Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus(HIV), or autoimmune disease? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 14. High blood pressure, heart disease, heart murmur, chest pain, or mitral valve prolapse? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 15. Mental or nervous problems? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 16. Arthritis, lupus, gout, fibromyalgia, fractures or limb loss? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 17. Cancer, tumors, or cysts? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 18. Genital herpes, syphilis, etc.? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 19. Is anyone to be covered currently pregnant?
Due date: (mm/dd/yyyy) _____ | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 20. Hepatitis? A B C D (circle one) | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 21. Any hospitalization in the last 5 years? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 22. Any future surgeries planned or being discussed? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 23. Any drug or alcohol problems? <input type="checkbox"/> Y <input type="checkbox"/> N When? _____ (mm/dd/yyyy)
Any treatment or rehab for drug or alcohol problems? <input type="checkbox"/> Y <input type="checkbox"/> N When? (mm/dd/yyyy) _____ | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 24. Disease of eyes, ears, nose, or throat (except glasses)? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 25. Had or are planning an organ transplant for you or covered dependent? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 26. Any illness or disease not listed above? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 27. Have you received any treatment in a physician's office or health care facility in the past year other than a routine physical
AND are still under medical care OR taking medication for that condition? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

Please give full details for all "Yes" questions above. Additional pages may be used but must be signed and dated.

Question #	Covered Person's Name	Diagnosis and Dates of Treatment	Medications	Is further treatment needed? Explain:

Please give full details for all "Yes" questions above. Additional pages may be used but must be signed and dated.				Is further treatment needed? Explain:
Question #	Covered Person's Name	Diagnosis and Dates of Treatment	Medications	

F CONDITIONS OF ENROLLMENT

I hereby apply for membership or request a change in membership in this WP/CHL Plan. I understand that my enrollment and benefits are in accordance with those described in the applicable Evidence/Certificate of Coverage or Certificate of Insurance, and Group Medical and Hospital Services Agreement or Group Policy. I authorize 1) all health providers and insurers to furnish WP/CHL, and 2) all health providers and WP/CHL to furnish all insurers and health providers records concerning me or any member of my family for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative is entitled to receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that all the above information is correct. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through WP/CHL. For purposes of collecting information for an insurance policy application, policy reinstatement, or a request for change in policy benefits, this authorization shall remain valid for thirty months from the date the authorization is signed. It is further understood that WP/CHL reserves the right to re-rate or rescind coverage if any supplied information is materially inaccurate or incomplete.

AGREEMENT AND AUTHORIZATION

By signing this form, I agree on behalf of myself and those family members enrolled in this WP/CHL Plan ("Dependents") for whom I have authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as Enrolled Family) that WP/CHL 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 treatment, payment, or health care operations, as those terms are explained in detail in WP/CHL's Notice of Privacy Practices and to the extent permitted by law. My Enrolled Family's consent includes agreement for the use or disclosure of health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV). By signing this form, 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, AIDS, ARC, or HIV to WP/CHL for WP/CHL's administration of health insurance benefits including treatment, payment, or health care operations purposes and other purposes permitted by law.

I HAVE READ AND AGREE TO THE STATEMENTS ABOVE.

Employee Signature	Employee Printed Name	Date
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