GHP
A Coventry Health Care Plan

ENROLLMENT & CHANGE FORM
2 - 25 Eligible Employees

Incomplete information will delay processing enrollment and member I.D. card.

EMPLOYER INFORMATION: *To Be Completed By Employer*

Company Name:	Group No.:	Subgroup:	Date Employed Full Time:	Effective Date of Coverage:	Benefits Administrator Approval:	Date:

Reason for Enrollment:
❑ New Group ❑ New Hire ❑ Open Enrollment
❑ Cobra ❑ Hardship ❑ Other: ____

Reason for Change:
❑ Addition ❑ Address/Phone ❑ Termination, Reason & Date: ____
❑ Coverage ❑ PCP Change, Reason: ____ ❑ Other: ____

Employee Status:
❑ Hourly ❑ Salary
❑ Retired ❑ Other: ____

EMPLOYEE INFORMATION: *To Be Completed By Employee*

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

Last Name:	First Name:	MI:	Social Security No.:
Street Address:			Work Phone & Area Code:
City:	State:	Zip:	Home Phone & Area Code:

Product Selection:
❑ Access (HMO) [1]
❑ Access Plus (POS) [2]
❑ Sensicare (HMO) [3]
❑ Sensicare Plus (POS) [4]
❑ HealthAssurance (PPO) [5]

Type of Coverage:
❑ Employee
❑ Employee/Spouse
❑ Employee/Children
❑ Employee/Spouse & Children
❑ Waive (see back)

Marital Status:
❑ Single
❑ Married
❑ Separated
❑ Divorced
❑ Widowed

MEMBER INFORMATION: *Family Members To Be Covered and Physician Selection*

All areas below must be filled out for each family member or it will delay processing enrollment. If "other" is checked, please indicate the nature of that relationship and include any appropriate legal documents. ***Note: PPO and Sensicare members do not need to select a physician.** ****Attention Female Illinois Members:*** ***You may designate an IL OB-Gyn as your Women's Principal Health Care Provider (WPHCP), in addition to your Primary Care Physician (PCP). Please write your WPHCP choice in the box labeled OB-Gyn name.***

RELATIONSHIP	ADD/DELETE	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY #	SEX	DATE OF BIRTH	PRIMARY CARE NAME & I.D. NUMBER	EXISTING PATIENT	*OB-GYN NAME	HEIGHT/ WEIGHT
❑ Self	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N		H ____ W ____
❑ Husband ❑ Wife	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N		H ____ W ____
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N		H ____ W ____
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N		H ____ W ____
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N		H ____ W ____
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N		H ____ W ____
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N		H ____ W ____

OTHER HEALTH INSURANCE INFORMATION: *Complete or Write N/A*

Name of Policy Holder:	Birthdate (mo/day/yr):	Social Security Number:	
Name of Employer:			
Name of Insurance Co. or Health & Welfare Plan:	Insurance Co. Phone No.:	Effective Date:	
Insurance Company Claim Address:	Insurance Policy No.:	Group No.:	
List of Family Members Covered:	Name of Anyone on Medicare?	Beneficiary No.:	Medicare A Eff. Date: Medicare B Eff. Date:

[1] Access (HMO) - underwritten by GHP
[2] Access Plus (POS) - HMO underwritten by GHP; Out-of-Network underwritten by Coventry Health & Life Insurance Co.
[3] Sensicare (HMO) - underwritten by GHP
[4] Sensicare Plus (POS) - HMO underwritten by GHP; Out-of-Network underwritten by Coventry Health & Life Insurance Co.
[5] HealthAssurance (PPO) - underwritten by Coventry Health & Life Insurance Co.

AGREEMENT: *Please read the following carefully.*

1. I apply for membership in Group Health Plan, Inc. (GHP) for myself and for any eligible dependents listed. I authorize my employer to make deductions, if any, toward the premium cost of GHP.
2. I and my eligible dependents shall abide by the provisions of coverage in the Group Enrollment Agreement, Certificate of Coverage and Benefit Riders under which we are enrolled.
3. By signing this form, I authorize my employer, & any physician, hospital, medical group or other facility providing me care, treatment or consultation, to disclose to GHP, or receive from GHP, any medical or claim information pertaining to the persons identified in this enrollment form receiving coverage under this plan, as may be necessary to enable GHP to make coverage determinations, pay claims or otherwise administer plan programs, including without limitation, credentialing of physicians and as applicable, other providers, all of which shall be conducted in accordance with state and federal confidentiality laws. GHP will not disclose any information pertaining to HIV/AIDS or chemical dependency/substance abuse except as specifically permitted by applicable law.
4. I understand and agree no benefits shall take effect until this application is approved by GHP.
5. I understand that my membership may be cancelled for one or both of the following reasons: (1) failure to pay the amount due under the Group Enrollment Agreement or Certificate of Coverage, for which I am legally responsible, or (2) fraud or material misrepresentation in enrollment or in the use of services of facilities.
6. I understand that it is my responsibility to report to GHP any change in the eligibility of myself or my dependents.

By signing this form I certify ALL information given is true and accurate.

Applicant's Signature: ____ Date: ____

HEALTH INFORMATION

- Health related questions are asked for rating purposes only.
- Explain ALL "Yes" responses to questions in space provided below.
- This section needs to be completed even if you are not applying for medical coverage.

1. Have you or your dependents had or been treated during the past ten (10) years for:
   - A. Disorders of the brain, muscular or neurological systems such as epilepsy, headaches, strokes, paralysis, head or spinal injuries, muscular dystrophy, cerebral palsy, multiple sclerosis, etc. ❑Yes ❑ No
   - B. Disorders of the heart or circulatory system such as anemia or blood disorders (sickle cell, pernicious, iron deficiency, arteriosclerosis, high blood pressure, heart problems, heart murmurs, chest pain, mitral valve prolapse, vascular diseases, artery or vein problems, etc. ❑Yes ❑ No
     If high blood pressure, please list current reading: ____________________
   - C. Disorders of the lung or respiratory system, such as asthma, hay fever, Emphysema, tuberculosis, hepatitis, allergies, etc. If allergies, what are you allergic to? ______________________________ ❑Yes ❑ No
   - D. Disorders of the digestive system such as colitis, diverticulosis, ulcers, gall bladder problems, hernias, liver disorders, rectum disorders, etc. ❑Yes ❑ No
   - E. Disorders of the genitourinary system such as bladder, kidney, prostate, renal failure, hormonal, uterine, testicular, breast problems, etc. ❑Yes ❑ No
   - F. Disorders of the endocrine system such as diabetes, high sugar, thyroid, or other glandular disorders, etc. ❑Yes ❑ No
   - G. Disorders pertaining to the eyes, ears, nose or throat. ❑Yes ❑ No
   - H. Disorders pertaining to mental, nervous, emotional or behavioral conditions, such as ADD/ADHD, eating disorder, sleep disorders, etc. (include professional counseling). ❑Yes ❑ No
   - I. Disorders of the bones or joints such as arthritis, lupus, gout, polio, fractures, limb loss, knee or hip problems, etc. If arthritis, give type: ______________________________ ❑Yes ❑ No
   - J. Disorders relating to cancer, tumors, cysts or other growths, skin disorders such as burns, etc. ❑Yes ❑ No
   - K. Disorders related to sexually transmitted diseases such as genital herpes, syphilis, etc. ❑Yes ❑ No
   - L. Disorders relating to the immune system such as AIDS or ARC, HIV positive, etc. ❑Yes ❑ No
2. Are you or a dependent currently pregnant? ❑Yes ❑ No
   - A. If yes, when is delivery expected? ____________________
   - B. Date of last menstrual period? ____________________
3. Have you or a dependent been hospitalized during the last 10 years? ❑Yes ❑ No
4. Have you or a dependent received regular chiropractic treatment(s) that are on going or anticipated? ❑Yes ❑ No
5. Are you or a dependent scheduled to have any medical attention or surgical treatment? ❑Yes ❑ No
6. Have you, or a dependent, been hospitalized during the past 24 months? ❑Yes ❑ No
7. Do you or a dependent have any mental or physical impairments, congenital anomaly or conditions, not mentioned in the previous general text that, if known, would prevent you from obtaining coverage? ❑Yes ❑ No
8. Have you or a dependent ever made an application for coverage at Group Health Plan? ❑Yes ❑ No
9. Have you or a dependent ever had alcohol or drug problems? ❑Yes ❑ No
   - A. If yes, when? ____________________
   - B. Do you belong to any associations to help? ____________________ ❑Yes ❑ No
10. Do you or a dependent currently drink or smoke cigarettes, cigar or a pipe? ❑Yes ❑ No
    If yes, how much? ____________________
11. Are you or a family member currently taking any medication? If yes, please give the member name, medication name, condition the medication is taken for, dosage and how often taken: ❑Yes ❑ No
    ____
    ____
    ____

IF YOU ANSWERED YES TO ANY QUESTIONS, PLEASE EXPLAIN BELOW

Question No.	Name	Diagnosis, Treatment & Medication	Dates of Treatment Length of Hosp. Stay	Is further treatment Needed? Explain	Name/Address of Doctor/Hospital

TO EXPEDITE THIS APPLICATION, PLEASE WRITE ON A SEPARATE SHEET OF PAPER ANY EXPLANATION YOU FEEL NEEDS MORE DETAIL THEN ALLOWED IN THE SPACES PROVIDED.

GENERAL PROVISIONS

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 (31) days of such marriage, birth, adoption, placement for adoption or court order.

2. RESOLUTION OF DISPUTES

Please refer to the Certificate of Coverage, which outlines in detail GHP's Member Grievance and Appeals Procedure.

FOR HEALTH PLAN USE ONLY			
Group Number:	Subscriber No.:	Date Entered/By:	Effective Date: