☐ Coventry Health Care of Delaware Inc. (CHCDE)
☐ Coventry Health and Life Insurance Company (CHL)
2751 Centerville Rd., Suite 400
Wilmington, DE 19808

☐ **NEW ENROLLMENT** ☐ **CHANGE**

Maryland Small Employer Enrollment Form

Fax:

A EMPLOYER INFORMATION

Company Name:	Group No.:	Date Employed:	Effective Date:

Reason for Enrollment:
☐ New Group ☐ New Hire ☐ Open Enrollment
☐ COBRA Start Date: _______ ☐ Other _______
☐ Qualifying Event (Reason & Date) _________
____

Reason for Change: (Please check all that apply and include supporting documentation)
☐ Enroll Dependent ☐ Address/Phone ☐ Term Dependent
☐ PCP Change ☐ Other ____________________
☐ Name Change (Previous Name) ____________________
☐ Termination, Reason & Date ____________________

Employee Status:
☐ Active ☐ COBRA
☐ Salary ☐Hourly
hours a week ______________
☐ Retired: Date ______________
☐ Other ______________

Benefits Administrator Approval: Date:

B SUBSCRIBER INFORMATION

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS:

CHCDE: ☐ POS _______ ☐ HMO ______ ☐ Qualified High Ded. Health Plan _________ ☐ Other ____________________
CHL: ☐ PPO ______ ☐ None/Waive (please complete section F)

Last Name	First Name	MI	M/F	Birth date	Height/ Weight	Social Security No. - -	Marital Status Please check one: ☐ Single ☐ Married ☐ Divorced ☐ Separated
Address		Work/Day Phone			Home Phone		
City	State	Zip	Email Address		PCP Name/ ID#/ Site Code (if Applicable)		Current Patient ☐ Yes ☐ No

C FAMILY MEMBERS TO BE COVERED OR DELETED

Enroll or Term	Full Name (Last, First, MI)	Gender	Relationship	Student	Birth date	Height	Weight	Social Security	PCP Name/ID#/Site Code (if applicable)	Current Patient
☐ E ☐ **T**		☐ M ☐ F	SPOUSE					- -		☐ Y ☐ N
☐ E ☐ **T**		☐ M ☐ F		☐ Y ☐ N				- -		☐ Y ☐ N
☐ E ☐ **T**		☐ M ☐ F		☐ Y ☐ N				- -		☐ Y ☐ N
☐ E ☐ **T**		☐ M ☐ F		☐ Y ☐ N				- -		☐ Y ☐ N
☐ E ☐ **T**		☐ M ☐ F		☐ Y ☐ N				- -		☐ Y ☐ N

Applicant Name: ______________________________

D TRANSITION OF CARE QUESTIONNAIRE

In order to assist you and your dependents with current medical needs and to provide transitional care to Coventry In-Network Providers, please complete the following. If needed, a nurse case manager will be in contact with you to assist in the transition of care to Coventry Health Care of Delaware or Coventry Health and Life Insurance Co. Your answers do not impact your benefits or rates as a Maryland small employer member.

DO YOU OR YOUR DEPENDENTS HAVE ANY OF THE FOLLOWING?

Treatment	**Yes**	**No**	**Member Name**	**Provider Name and Number**
Dialysis	☐	☐		
Chemotherapy	☐	☐		
Radiation Therapy	☐	☐		
Equipment/Services	**Yes**	**No**	**Member Name**	**Provider Name and Number**
Home Health	☐	☐		
Durable Medical Equipment	☐	☐		
Outpatient/Rehab. Therapy	☐	☐		
Please list Pending Procedures/Surgery	**Yes**	**No**	**Member Name**	**Provider Name and Number**
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
History of Transplant/Major Surgery or Illnesses (Please List)	**Yes**	**No**	**Member Name**	**Provider Name and Number**
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
Are you currently pregnant?	**Yes** ☐	**No** ☐	**Member Name**	**Provider Name and Number**
Are you currently taking any Prescription Drugs	**Yes** ☐	**No** ☐	**Member Name**	**Provider Name and Number**

E OTHER MEDICAL AND/OR PHARMACY COVERAGE INFORMATION

When coverage with Coventry begins, will you or your dependents have any other medical insurance coverage? Self: ☐ Yes ☐ No Spouse**:** ☐ Yes ☐ No Dependents**:** ☐ Yes ☐ No

Other Insurance Company Name	Name of policyholder	M / F	Birth date	Effective Date

Covered Dependents: Relationship to Policyholder: ☐ Spouse ☐ Daughter ☐ Son	Covered Dependents: Relationship to Policyholder: ☐ Spouse ☐ Daughter ☐ Son
Covered Dependents: Relationship to Policyholder: ☐ Spouse ☐ Daughter ☐ Son	Covered Dependents: Relationship to Policyholder: ☐ Spouse ☐ Daughter ☐ Son

Coverage Type:

☐ Group Policy ☐ Individual Policy ☐ Medicare ☐ Pharmacy ☐ Medicaid ☐ Tricare

Medicare Information

☐ Subscriber or ☐ Dependent Effective Date: / / Reason for Medicare Eligibility	☐ Subscriber or ☐ Dependent Effective Date: / / Reason for Medicare Eligibility
Part A / / ☐ Over 65 ☐ Disabled ☐ Kidney Disease (ESRD)	Part A / / ☐ Over 65 ☐ Disabled ☐ Kidney Disease (ESRD)
Part B / / ☐ ALS (Lou Gehrig's Disease	Part B / / ☐ ALS (Lou Gehrig's Disease
Part D / / Medicare #:	Part D / / Medicare #:

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 the reason indicated below.

☐ Other Health Coverage ☐ Spousal Coverage ☐ Other Reason (please explain) ______________________________

You may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

G AGREEMENT AND AUTHORIZATION

I hereby apply for myself and dependents, if any, listed hereon. The application is subject to acceptance, and if accepted, to the waiting periods, exclusions and other provisions contained in the subscription agreement(s). I agree that in order to qualify for HMO benefits that are not Open Access, services must be obtained from or authorized by the appropriate participating Health Plan provider, except for emergency and out-of-area services.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information, as permitted by law, pertaining to medical history or services rendered to Us for any administrative purposes, including evaluation of an application or claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original. I have carefully read this subscription application and agree to the terms specified herein. The foregoing statements are complete, true to the best of my knowledge and belief.

If you have any questions concerning benefits and services provided by or excluded under this agreement please contact Member Services at 1-800-833-7423.

I HAVE READ AND AGREE TO THE STATEMENTS ABOVE.

Applicant Signature	Applicant Printed Name	Date