

Enrollment / Change Form

Delaware Small Group



* 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

New Group New Enrollment Change Waive (please complete section F)

Company Name:	*Group No.:
Date Employed Full Time: <input type="text"/> / <input type="text"/> / <input type="text"/>	*Effective Date of Coverage or Change: <input type="text"/> / <input type="text"/> / <input type="text"/>
<p>**REASON FOR ENROLLMENT:</p> <p><input type="checkbox"/> New Group <input type="checkbox"/> New Hire <input type="checkbox"/> COBRA/State Continuation <input type="checkbox"/> Retired <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Qualifying Event (Reason) Date ____/____/____</p>	
<p>**REASON FOR CHANGE: (Please check all that apply and include supporting documentation.)</p> <p><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 <input type="checkbox"/> PCP Change</p>	
<p>Termination Reason:</p> <p><input type="checkbox"/> Group Request <input type="checkbox"/> Member Request <input type="checkbox"/> Deceased</p>	
<p>EMPLOYEE STATUS:</p> <p><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 _____</p>	
Benefits Administrator Approval:	Date:

B SUBSCRIBER INFORMATION

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS:

HMO¹ POS¹ PPO² QHDHP PPO² Other _____

Type of Coverage: Employee Employee/Spouse Employee/Children Employee/Spouse/Children

*Last Name	*First Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
*Gender	*Birthdate	*Social Security Number
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>
*Address		
<input type="text"/>		
*City	*State	*Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Email Address		
<input type="text"/>		
Height	Weight	Marital Status (please check one.)
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Single/Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated
Work Phone		Home Phone
<input type="text"/> - <input type="text"/> - <input type="text"/>		<input type="text"/> - <input type="text"/> - <input type="text"/>
		▲Primary Care Physician ID# Site Code
		<input type="text"/>
		Current Patient
		<input type="checkbox"/> Yes <input type="checkbox"/> No

C FAMILY MEMBERS TO BE COVERED OR DELETED

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

<input type="checkbox"/> Add <input type="checkbox"/> Delete	*Last Name	*First Name	MI
	<input type="text"/>	<input type="text"/>	<input type="text"/>
*Gender	*Relationship	Student / Disabled	*Birthdate
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> Student <input type="checkbox"/> Disabled	<input type="text"/> / <input type="text"/> / <input type="text"/>
			Social Security Number
			<input type="text"/> - <input type="text"/> - <input type="text"/>
		Height	Weight
		<input type="text"/>	<input type="text"/>
		▲Primary Care Physician ID# Site Code	
		<input type="text"/>	
		Current Patient	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

<input type="checkbox"/> Add <input type="checkbox"/> Delete	*Last Name	*First Name	MI
	<input type="text"/>	<input type="text"/>	<input type="text"/>
*Gender	*Relationship	Student / Disabled	*Birthdate
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> Student <input type="checkbox"/> Disabled	<input type="text"/> / <input type="text"/> / <input type="text"/>
			Social Security Number
			<input type="text"/> - <input type="text"/> - <input type="text"/>
		Height	Weight
		<input type="text"/>	<input type="text"/>
		▲Primary Care Physician ID# Site Code	
		<input type="text"/>	
		Current Patient	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Applicant Name: _____

E HEALTH INFORMATION

(Please answer each question fully and accurately. Incomplete answers could delay the processing of your requested coverage.)

Please provide the health history of you and your family members who will be covered on this application. Please CIRCLE all applicable conditions and provide details for all "YES" answers in the appropriate section. Conditions include but are not limited to the following:

	Yes	No
1. Cancer, tumor, or cyst		
2. Epilepsy, stroke, or paralysis		
3. Head or spinal injuries, Muscular Dystrophy, Cerebral Palsy, or Multiple Sclerosis		
4. Neck or back pain, disorders of the spine, or disk herniation/bulge		
5. Any blood disorder (such as: anemia, sickle cell, or hemophilia)		
6. Bladder, kidney, (kidney failure or dialysis), prostate, testicular, uterine, or breast conditions		
7. Vascular (blood vessel) disease		
8. Ulcerative colitis, Crohn's, diverticulitis, stomach ulcers, acid reflux, hernia, gallbladder, or rectal disorders		
9. Asthma, allergies, or hay fever		
10. Emphysema, COPD, Cystic Fibrosis, or any other lung/respiratory disorder		
11. Diabetes? Type I or II (Please give full details below)		
12. High Blood Pressure		
13. Heart disease, irregular heartbeat, heart murmur, chest pain, or heart valve conditions		
14. HIV or AIDS		
15. Cigarette or tobacco use _____ If YES, type of product and how much per day _____		
16. Thyroid, pituitary, pancreas, glandular, or disorder requiring growth hormones		
17. Mental or nervous problems		
18. Diseases of the eyes, ears, nose, sinuses, or throat (except glasses)		
19. Arthritis, joint pain, lupus, fibromyalgia, fractures, or limb loss		
20. Hepatitis Type: A, B, C, D (Please circle) OR any other liver disorder/disease		
21. Any drug or alcohol problems		
22. Treatment or rehab for drug or alcohol problems When _____ (month/year)		
23. Any organ transplant (planned, recommended, or already performed)		
24. Is any female to be covered currently pregnant Due Date _____ (Month/day/year)		
25. Any hospitalizations in the last 5 years (Please give full details below)		
26. Any future surgeries discussed, planned, or recommended (Please give full details below)		
27. Currently taking any prescription medications (Please give full details below)		
28. Are there any other medical conditions not listed above (Please give full details below)		

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

Question Number	Person's Name	Condition	Treatment (Month / Year)	Medications (oral, injectable, infusion, or inhaled)	Is further treatment needed? If yes, please explain:

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: Spousal coverage - Spouse's Employer _____ Medicare/Medicaid

Other reason (please explain) _____

Warning: Employees who decline medical coverage for themselves and/or dependents during the initial enrollment period and then, more than 31 days later, request coverage will be considered a late enrollee. Coverage for late enrollees is effective at the next Open Enrollment Period. However, an eligible employee will not be considered a late enrollee for employee and/or dependent coverage (and coverage will not be deferred) if: (a) late enrollment is made under one of the circumstances described below; and (b) any required information or proof is furnished.

Late Enrollee Exceptions: An eligible employee will not be considered a late enrollee for employee and/or dependent coverage if (a) late enrollment is requested within 31 days of the qualifying event listed below; and (b) any required information or proof is furnished.

1. Termination of Other Health Coverage; 2. Court Order; 3. Election of Different Plan During Open Enrollment Period: The employer offers multiple health plans, and request for enrollment under this plan is made during the open enrollment period established by for plan election.

I hereby acknowledge the above warning regarding the consequences of declining medical coverage at my initial enrollment. I declare that the information given on this waiver is correctly recorded, complete and true.

For an Employee whose spouse is employed by the State of Delaware: I understand that the following policy applies to spouses who regularly work full-time and are eligible for medical coverage through their own employers:

• This information will be shared with the State of Delaware's plan administrator(s).

• If spouses take advantage of their own employer's medical coverage, their plans pay their benefits first. Then the State of Delaware will pay additional covered expenses, if any, up to the maximum allowed under our employee's family benefit plan, not exceeding a limit of 100% coverage from both plans combined.

• If spouses do not take advantage of their own employer's medical coverage, the State will pay 20% of covered services provided by the employer's family State of Delaware benefit plan.

This policy does not apply to:

• Spouses not working full time, or

• Spouses whose employers do not offer medical coverage, or

• Spouses whose employers require a contribution of more than 50% of the premium for the lowest benefit plan available, and

• Eligible dependent children.

Employee Signature (only if you are waiving coverage)

Date:

G AGREEMENT AND AUTHORIZATION Please read the following carefully.

- I am applying for covered services for which I and my dependents are eligible for under the Coventry Health Care of Delaware, Inc. (CHCDE) Group Contract.
- If applicable, I authorize my employer to deduct the appropriate premium amount from my earnings.
- I agree on behalf of myself and my dependents to abide by the terms of the agreement describing my coverage.
- I authorize any provider who provides services to me or my dependents to release to CHCDE and its participating providers any information or medical records relating to those services.
- I will complete and sign any documents necessary for CHCDE to assume my or my dependents legal rights to collect from a third party, any costs that CHCDE may incur.
- I understand that the CHCDE Group Contract contains a provision which obligates me to follow a complaint procedure for any claim or dispute regarding coverage.

By signing this form I certify all information on this form is true and correct to the best of my knowledge.

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

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

Applicant Signature

Date

Applicant Printed Name

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

2. RESOLUTION OF DISPUTES - Please refer to the Group Membership Agreement, which outlines in detail CHCDE/CHL's Member Complaint and Appeals Procedures.

¹ Underwritten by Coventry Health Care of Delaware, Inc.

² Underwritten by Coventry Health and Life Insurance Company

▲ Complete if required. PCP ID is found in the Provider Directory or at www.chcde.com. Such fields only need to be completed when enrolling in the Coventry G and Coventry F plans.