HEALTHAMERICA
A Coventry Health Care Plan

New Business Small Group Statement of Health/Employee Application

PA ONLINE

Pennsylvania in-area PPO and CCPPO (POS) products are underwritten by HealthAssurance Pennsylvania, Inc. (d.b.a HealthAmerica). All out-of-area PPO products and Ohio in-area PPO products are underwritten by Coventry Health and Life Insurance Company (d.b.a HealthAmerica). HMO products are underwritten by HealthAmerica Pennsylvania, Inc.

A. EMPLOYER INFORMATION (To Be Completed by Employer)

Group Name

B. SUBSCRIBER INFORMATION (To Be Completed by Employee)

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS:

☐ **PPO**____________ ☐ OA PPO ___________ ☐ Other _____________ ☐ None / Waive (Go to Section E)

Type of Coverage: ☐ Employee ☐ Employee/Spouse ☐ Employee/Child/Children ☐ Family

EMPLOYEE STATUS Date employed full time: _________

Please check one No. of hours per week _________

❏ Active ❏ Retired ❏ Salary ❏ Hourly

❏ COBRA start date______end date __________

LAST NAME	FIRST NAME	MI	M/F	BIRTHDATE	HEIGHT	WEIGHT	SOCIAL SECURITY NO.
ADDRESS				EMAIL ADDRESS			
CITY	STATE	ZIP	HOME PHONE	WORK PHONE			

MARITAL STATUS
Please check one:
❏ Single/Widowed
❏ Married
❏ Divorced

C. FAMILY MEMBERS TO BE COVERED (all information is required, including Social Security numbers)

FULL NAME (Last, First, MI)	HEIGHT	WEIGHT	SEX	RELATIONSHIP	BIRTHDATE	STUDENT	SOCIAL SECURITY #
			M F	SPOUSE	/ /		-- --
			M F		/ /	Y N	-- --
			M F		/ /	Y N	-- --
			M F		/ /	Y N	-- --
			M F		/ /	Y N	-- --
			M F		/ /	Y N	

D. OTHER INSURANCE

WHEN coverage with HealthAmerica **BEGINS**, will you or any of your dependents have any other medical insurance coverage? ❑ Yes ❑ No

Do you or your covered dependents have Medicare Coverage? ❑Yes ❑No If Yes, please complete the following:

Name: _______________________________ Medicare ID No. _________________ Part A Effective Date____________ Part B Effective Date____________________

E. 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 – Spouses' Employer ______________________________________

❏ Medicare/Medicaid ❏ Other reason (please explain) ____

Warning: Employees who decline medical coverage for themselves and/or dependents during the initial enrollment period then request coverage after 31 days will be considered late enrollees. Coverage for late enrollees is effective at the next open enrollment period. However, eligible employees will not be considered late enrollees 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: 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; 4. Marriage; 5. Birth; 6. Adoption or placement for adoption.

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

X **Employee Signature (ONLY IF YOU ARE WAIVING COVERAGE)** Date:

F. HEALTH INFORMATION (Please answer each question fully and accurately to the best of your knowledge. Incomplete answers will delay the processing of your requested coverage.

Please provide the health history for yourself and other family members **applying** for coverage on this application. **All** questions must be checked with a "Yes" or "No" response, **CIRCLE** any past or current condition(s), and provide corresponding details in the appropriate section. Have you or anyone applying for coverage been diagnosed, treated or advised to have treatment by a medical professional for any of the following conditions:

	YES	NO		YES	NO
1. Cancer, tumor or cyst.			13. Thyroid, pituitary, pancreas or glandular disorders or disorders requiring growth hormones.		
2. Epilepsy, stroke, or paralysis.			14. Sleep apnea or diseases of the throat, ears, nose sinuses, or eyes (except glasses).		
3. Head or spinal injuries, muscular dystrophy, cerebral palsy, or multiple sclerosis.			15. Arthritis (osteo, rheumatoid, or other), joint pain, lupus, fibromyalgia, fractures, or limb loss, vasculitis, or peripheral vascular disease.		
4. Neck or back pain, disorders of the spine, or disk herniation/bulge.			16. Hepatitis Type (please circle): A, B, C, D or autoimmune hepatitis OR any other liver disorder/disease.		
5. Any blood disorder such as anemia, sickle cell or hemophilia.			17. Any drug or alcohol problems (Please give full details below to include any treatment or rehab.)		
6. Bladder, kidney (kidney failure or dialysis), prostate, testicular, uterine, or breast conditions.			18. Cigarette or tobacco use? If YES, type of product and how much per day? ____________________________		
7. Ulcerative colitis, Crohn's, diverticulitis, stomach ulcers, acid reflux, hernia, gallbladder, or rectal disorders.			19. Is any female to be covered currently pregnant? Due Date_____________(Month/Day/Year) If YES, How many babies? _______ (single, twins, triplets, etc) (If pregnant, please give details below to include any complications.)		
8. Emphysema, COPD, cystic fibrosis, Asthma, or any other lung/respiratory disorder.			20. Any stem cell or organ transplant (planned, recommended, or already performed).		
9. Diabetes Type I or II (please give full details below)			21. Any hospitalizations in the last 5 years (Please give full details below)		
10. Heart disease, irregular heartbeat, heart murmur, regurgitation, chest pain, congestive heart failure, or heart valve conditions.			22. Any future surgeries discussed, planned or recommended (Please give full details below)		
11. Diagnosis of AIDS or AIDS-related condition; Positive result, other than a false positive or HIV test.			23. Currently taking any prescription medications? (Please give details below to include the name of the medication and condition for which the medication is needed)		
12. High Blood Pressure (hypertension)			24. 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 (include start date of condition)**	**Types of Treatment (Month/Year)**	**List all Medications by name** (oral, injectable, infusion, or inhaled)	Is Ongoing Treatment Needed? If Yes, Please Explain:

G. CONDITIONS OF ENROLLMENT

I AGREE: All information on this form and the attached health questionnaire is correct and true. I understand that it is the basis on which premiums may be determined under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment at least 25 hours a week. Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded. I ACKNOWLEDGE THAT I am applying for Preferred Provider Organization (PPO) coverage: I understand that if I or one of my dependents receive medically necessary covered services from a nonparticipating provider, HealthAmerica will cover only the lower level benefits set forth in the applicable certificate of insurance and I will be responsible for payment of any amount not covered by HealthAmerica. AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION. I authorize any insurance company, physician, hospital, clinic, health care provider or other organization, institution or person having records or knowledge of anyone listed on this application to give HealthAmerica or their designated agent any and all records pertaining to any medical history, services or treatment provided to anyone on this application for purposes of review, investigation or evaluation of coverage. This authorization and any copy thereof is valid for 30 months from the date signed. I, the applicant, acknowledge that I have read and understand the application in its entirety. OHIO: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. ELECTRONIC COMMUNICATIONS: I ACKNOWLEDGE AND UNDERSTAND THAT BENEFIT DOCUMENTS, LEGAL DOCUMENT, AND PROVIDER NETWORK INFORMATION FOR HEALTHAMERICA PLANS WILL BE MADE AVAILABLE TO ME IN ELECTRONIC FORMAT THROUGH THE HEALTHAMERICA WEBSITE AND MY ONLINE SERVICES AT WWW.HEALTHAMERICA.CVTY.COM. MY ENROLLMENT IN THE PLAN INCLUDES THIS ELECTRONIC ACCESS. TO RECEIVE PRINTED DOCUMENTS AT NO COST TO ME, I MUST CONTACT CUSTOMER SERVICE TOLL-FREE AT 1-800-788-8445 IN CENTRAL AND EASTERN PA OR 1-800-735-4404 IN WESTERN PA AND OH.

I HAVE READ AND AGREE TO THE CONDITIONS OF ENROLLMENT (Signature Required Below – signature/date valid for 60 days)

Employee Signature	**Employee Printed Name**	**Date**