Mail To: Group Health Plan
Attn: Individual Department
550 Maryville Centre Drive, Ste. 300
St. Louis, MO 63141-5818
Fax: (866) 255-2763

GHP
A Coventry Health Care Plan

CoventryOne.

Check One
☐ New Enrollment
☐ Change Form

MISSOURI

FAMILY ENROLLMENT APPLICATION/CHANGE FORM

Products are underwritten by Group Health Plan, Inc. and/or Coventry Health and Life Insurance Co. Incomplete information may delay your enrollment and/or your member ID card.

A INDIVIDUAL INFORMATION (To be completed by applicant)

Last Name	First Name	MI	Sex M / F	Date of Birth	Social Security No.	Requested Effective Date: ☐ Day of Coventry*One* Approval OR ☐ ___/___/___
Address					E-Mail Address	Business Phone ( ) -

City	State	Zip Code	County	Home Phone ( ) -	Height	Weight	Tobacco Use Yes / No

B BENEFIT SELECTION **Please select the benefit plan for which you are requesting coverage.**

MISSOURI

☐ **PPO 100/60 - 500**	☐ **PPO 100/60 - 2000**	☐ **PPO 80/50 - 500**	☐ **PPO 80/50 - 2000**
☐ **PPO 100/60 - 1000**	☐ **PPO 100/60 - 3000**	☐ **PPO 80/50 - 1000**	☐ **PPO 80/50 - 3000**
☐ **PPO 100/60 - 1500**	☐ **PPO 100/60 - 5000**	☐ **PPO 80/50 - 1500**	☐ **PPO 80/50 - 5000**

HSA Plans

☐ **PPO 100/60 - 1500**	☐ **PPO 100/60 - 2000**	☐ **PPO 100/60 - 3000**	☐ **PPO 100/60 - 5000**

SJ Plans

☐ **PPO 100/60 - 1500**	☐ **PPO 100/60 - 2500**	☐ **PPO 100/60 - 3000**	☐ **PPO 100/60 - 5000**

C FAMILY MEMBERS TO BE COVERED OR DELETED

Full Name (Last, First, MI)	Gender	Relationship	Age	Birthdate	Student or Disabled Dependent	SS Number	Height (ft.in.)	Weight (lbs.)	Tobacco Use Yes/No
	M / F	SELF		/ /	-------	- -			
	M / F	SPOUSE		/ /	-------	- -			
	M / F			/ /	S / D	- -			
	M / F			/ /	S / D	- -			
	M / F			/ /	S / D	- -			

Are you, or anyone else applying for coverage, required to provide health care coverage for a child pursuant to a Qualified Medical Child Support Order or other court order? ☐ **No** ☐ **Yes**

If yes, please list the children.	Child's Name	Responsible Party
	1. _____	_____
	2. _____	_____
	3. _____	_____
	4. _____	_____

D HEALTH SAVINGS ACCOUNT (HSA) OPTION FOR QHDHP ONLY

Your Health Savings Account (HSA) is your financial asset even if you change health plans or are no longer covered by GHP. To open an HSA you must meet three criteria:

1) You must be covered by a Qualified High Deductible Health Plan (QHDHP).
2) You cannot be covered by another health plan, including Medicare.
3) You cannot be claimed as a dependent on another individual's tax return.

If you have selected a GHP Qualified High Deductible Health Plan (QHDHP) and are otherwise eligible, you will receive a Health Savings Account (HSA) through our HSA trustee, HealthEquity, at no additional charge. You will be able to contribute to this tax-advantaged account to help you put aside money to fund your medical claims before meeting your deductible and save for future medical expenses. As an additional benefit, HealthEquity will provide 24/7 telephonic support and online information to help you better manage this account. If you have selected a GHP QHDHP product and **do not want** to take advantage of the HSA account, please check the box below. Otherwise you will receive a welcome kit and HSA Debit Card from HealthEquity once your GHP QHDHP application is accepted.

☐ **OPT–OUT of having an HSA opened through HealthEquity**

E PREMIUM PAYMENT

Upon final approval of this application, GHP will notify you of the exact premium and effective date. Premiums will be drawn from this account on the 10th calendar day of each month. If premiums and/or effective date differ from quotes, no funds will be drawn prior to notification and acceptance by applicant. **Attach a voided check** from account listed below. For members with a 15th of the month effective date, the first premium withdrawal, which will occur on the 10th of the following month, will be in the amount equal to one and one half (1½) month's of premium. Each subsequent month, the withdrawal will be for one (1) month's premium.

Please provide: ☐ Checking Account ☐ Savings Account

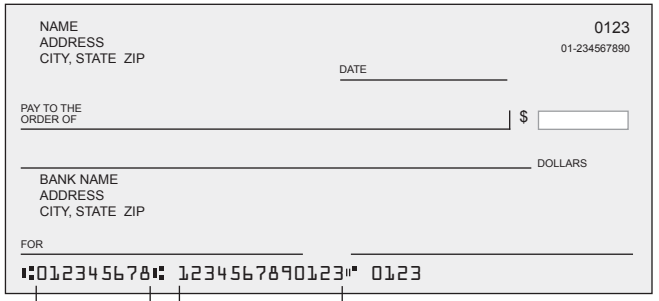
Name of Bank or Saving Institution _____

Routing Number _____ Account Number _____

Name that appears on the Account _____

I authorize Group Health Plan to initiate automatic withdrawal from the bank and account indicated above on behalf of the Applicant named above. I understand it is my responsibility to notify GHP if I change banks or account numbers.

Account Holder Signature _____ Date _____



F STATE MANDATED CONTRACEPTIVE BENEFITS ELECTION (for Missouri residents only)

☐ I wish to include coverage for contraceptives.

☐ I wish to exclude coverage for contraceptives because of moral, ethical or religious beliefs.

G PHASE II CLINICAL TRIAL RIDER (for Missouri residents only)

☐ I wish to include coverage for Phase II Clinical Trials *(additional premium applies).*

H OTHER HEALTH INSURANCE

Do you have other health coverage? ☐ No (Skip to section I) ☐ Yes (Complete this section)

Policyholder Name	Policyholder Date of Birth / /	Name of Insurance Company	Contract # / Group #	Policy Eff Date / /	Policy Term Date / /

Do you have or are you eligible for coverage under Medicare? ☐ No ☐ Yes **If Yes, you are not eligible for this coverage.**

I BROKER INFORMATION (if applicable)

Name of Broker _____ Broker ID Number _____

Signature of Broker _____ Fax Number _____

J HOW DID YOU HEAR ABOUT US?

☐ Internet ☐ Radio ☐ Broker
☐ Friend / Relative ☐ Newspaper Ad
☐ Other _____

K HEALTH HISTORY **Please check Yes or No and provide details for all Yes answers on page 3. Please circle all conditions that apply.**

Within the past five (5) years have you or any dependents listed on this form consulted or sought treatment, been diagnosed, had treatment recommended, received medical treatment or therapy, been surgically treated or been hospitalized for any of the following conditions? Incomplete applications may be rejected or returned to you for completion.

1. Heart attack, heart murmur, irregular heart rate, stroke, chest pain, high blood pressure, angioplasty, rheumatic fever, congestive heart failure, heart or valve disorder? List last three blood pressure readings, if applicable: _____ _____ _____	Yes ☐	No ☐
2. Hyperlipidemia, high cholesterol, arterio-sclerosis, circulatory or vascular problems, hemophilia, blood clots, anemia, blood vessels or bleeding disorder? List last three cholesterol readings, if applicable: _____ _____ _____	Yes ☐	No ☐
3. Stomach ulcer, colitis, Crohn's disease, hernia, hepatitis, liver disease or disorder of the stomach, intestines, pancreas, rectum or gall bladder?	Yes ☐	No ☐
4. Cancer, cysts, polyps, tumor or growth of any kind?	Yes ☐	No ☐
5. Disorder of the kidneys, prostate or urinary system, kidney failure, blood or albumin in urine or receiving dialysis?	Yes ☐	No ☐
6. Tuberculosis, emphysema, cystic fibrosis, COPD, bronchitis, asthma, allergies, sleep apnea, pneumonia, pleurisy, deviate nasal septum or disorder of the lungs or respiratory system?	Yes ☐	No ☐
7. Epilepsy, alzheimer's disease, fainting spells, migraines, frequent headaches, attention deficit disorders, paralysis, brain or neurological disorders? If epileptic, date of last seizure: _____ ☐ grand mal ☐ petit mal	Yes ☐	No ☐
8. Lupus, fibromyalgia, arthritis, fractures, back or spinal conditions, or disorder of the joints, muscles or bones?	Yes ☐	No ☐
9. Any bodily injury, concussion, burns, congenital problems or defects? Any chronic infections or infectious diseases?	Yes ☐	No ☐
10. Diabetes or abnormal glucose test (high / low)? If diabetes, Type: ☐ I ☐ II Any complications? _____ If applicable, list A1C reading _____ or last three blood sugar readings: _____ _____ _____	Yes ☐	No ☐
11. Donor, recipient or a candidate for a transplant? When? _____	Yes ☐	No ☐
12. Any amputations, prosthetic devices or implants?	Yes ☐	No ☐
13. Positively diagnosed or treated for any immune deficiency disorder, including, but not limited to HIV, AIDS or AIDS-related complex?	Yes ☐	No ☐
14. Any neurological or muscular disorders such as cerebral palsy, multiple sclerosis, muscular dystrophy, parkinson's disease?	Yes ☐	No ☐
15. Cataracts, glaucoma, macular degeneration, retinopathy, strabismus, eye disorders, ear infections, ear disorder or hearing impairment?	Yes ☐	No ☐
16. Thyroid, pituitary or adrenal gland disorder?	Yes ☐	No ☐
17. Any skin disorders such as psoriasis, acne, eczema, dermatitis, herpes, shingles, severe scars?	Yes ☐	No ☐
18. Abnormal pap smear or mammogram, breast disorder, disorder of male or female organs or menstrual dysfunction? Date last pap smear: _____ Result: _____	Yes ☐	No ☐
19. Disorders relating to sexually transmitted diseases such as genital warts (HPV), genital herpes, syphilis, etc.?	Yes ☐	No ☐
20. Are you or any family member pregnant or have reason to suspect you or they are pregnant? Due date? _____ Date of last menstrual cycle: _____	Yes ☐	No ☐
21. Been treated, counseled, or advised to seek treatment regarding use of alcohol, illegal substance, narcotics or prescription drugs?	Yes ☐	No ☐
22. Sought or been advised to seek psychiatric, psychological or mental health treatment or counseling?	Yes ☐	No ☐
23. Manic depression, bipolar, panic attacks, schizophrenia, obsessive-compulsive disorder (OCD), depression or behavioral disorder?	Yes ☐	No ☐
24. Anorexia, bulimia, gastric bypass or other eating disorders?	Yes ☐	No ☐
25. Had an X-ray, electrocardiogram, cardiac catheterization, MRI, CT scan, ultrasound or other diagnostic test or procedure?	Yes ☐	No ☐
26. Any pending or recommended surgery or procedure not yet performed or have been advised to obtain equipment or services?	Yes ☐	No ☐
27. List any disease, condition or impairment not mentioned above:		
28. Have you been treated in the emergency room or hospitalized in the past 5 years?	Yes ☐	No ☐
29. Have you used tobacco products in the past 12 months? If Yes, what kind? _____ Frequency: _____ Date of last use (if quit): _____	Yes ☐	No ☐

30. Please list any current medication or any taken in the past twelve (12) months, including injection therapy.

Enrollee Name	Name of Medication	Dosage / Frequency	Prescribing Physician

31. Name of applicant's current physician: Address: Phone #: Date and reason last consulted:

32. Name of dependent's current physician: Address: Phone #: Date and reason last consulted:

If you answered “Yes” to any of the previous medical questions, you must complete the requested information about those conditions. Please explain and provide FULL DETAILS for each “Yes” answer to any condition(s) checked in the preceding boxes. Please give details on the last doctor visit and/or physical examination regardless of date or reason. Insert additional sheets if necessary.

Name of Applicant ______________________________

Question #	Condition or Diagnosis	
Date of Onset / Treatment (Month / Year) Date Ended Still Under Treatment? Y / N	Treatment Rendered	
Medication (if taken) / Date Prescribed / Dosage		
Name of Hospital, Clinic or person providing care	Address	Phone #

Question #	Condition or Diagnosis	
Date of Onset / Treatment (Month / Year) Date Ended Still Under Treatment? Y / N	Treatment Rendered	
Medication (if taken) / Date Prescribed / Dosage		
Name of Hospital, Clinic or person providing care	Address	Phone #

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Medication (if taken) / Date Prescribed / Dosage		
Name of Hospital, Clinic or person providing care	Address	Phone #

Question #	Condition or Diagnosis	
Date of Onset / Treatment (Month / Year) Date Ended Still Under Treatment? Y / N	Treatment Rendered	
Medication (if taken) / Date Prescribed / Dosage		
Name of Hospital, Clinic or person providing care	Address	Phone #

L HIPAA ELIGIBILITY (for Missouri residents only)

If you do not qualify for our standard pricing structure because of your health, you may qualify for our plans as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Individuals who qualify for HIPAA are guaranteed acceptance in the plan of your choice with no lapse in coverage. The premium for the HIPAA program is considerably higher than our standard rates. Please see separate HIPAA Information sheet and rates.

True	False	
☐	☐	1. You have had coverage for at least 18 months without a break in coverage of 63 days or more;
☐	☐	2. The most recent coverage you have had is through a group, governmental or church health plan;
☐	☐	3. Your coverage was not terminated because of fraud or nonpayment of premiums;
☐	☐	4. You are not eligible for COBRA continuation of coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision). Dates of coverage: _____ to _____;
☐	☐	5. You are not eligible for a group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.
☐	☐	6. If all answers are true above, do you want to be considered for the HIPAA program? Please see HIPAA information sheet for rates and plans.

Failure to answer the questions under this section may result in the loss of your rights as an eligible individual including the waiver of the pre-existing condition exclusion. It is your responsibility to provide a certificate of creditable coverage in order to determine your HIPAA eligibility.

M ENROLLMENT AGREEMENT (Please read the following carefully)

Benefits are underwritten by Group Health Plan, Inc. and/or Coventry Health and Life Insurance Co.

In consideration of the payment of Premiums and in accordance with the terms and provisions of this Enrollment Application/Change Form, the Certificate of Coverage ("COC") and Amendments, applicable Riders, the Schedule of Benefits, and Member Handbook and Provider Directory (collectively referred to as the "Agreement"),

For PPO applicants: Coventry Health and Life Insurance Company (CH&L) as the underwriter and Group Health Plan, Inc. ("GHP") as the administrator shall provide coverage for medical and hospital services to "Member."

I. EFFECTIVE DATE AND TERM OF AGREEMENT
This Agreement shall be effective on date defined in the Approval Letter sent with the COC, ("Effective Date" as defined in the COC) at 12:01 a.m. Local Time.

II. PREMIUM DUE DATE AND PAYMENTS
The 1st day of the coverage month hereunder is the "Premium Due Date." Member agrees to make funds in the amount of the Premium set forth in the Approval Letter available to GHP through automatic withdrawal as authorized on this Enrollment Application/Change Form on or before the Premium Due Date. In the event the full amount of the Premium is not made available by Member through such bank account, a 31-day grace period ("Grace Period") shall be granted to Member for payment without interest charge. However, payment will be required by check. If payment is not received by the expiration of the Grace Period, GHP reserves the right to terminate coverage pursuant to Section V of this Agreement and the Termination of Coverage Section of the COC. Premiums outstanding subsequent to the Premium Due Date and Grace Period may be subject to a late penalty charge of 1.50% of the total premium amount due, calculated for 31-day period(s), or the portion thereof that remains outstanding and due prior to termination of Member. Members for whom payment is received by GHP shall be eligible for services and benefits for the period covered by such payment. If this Agreement is terminated for any reason, Member shall continue to be liable for any costs incurred by GHP prior to notice of termination, including, but not limited to, costs incurred by GHP during Grace Period for Health Services as that term is defined in the COC, and costs of collection.

For members with a 15th of the month effective date, the first premium withdrawal, which will occur on the 10th of the following month, will be in the amount equal to one and one half (1½) month's of premium. Each subsequent month, the withdrawal will be for one (1) month's premium.

III. PREMIUM RATE CHANGES
GHP may change the Premium every contract year and any time thereafter by giving no less than 30 days prior written notice to the Member. The Premium shall not be revised more than once in any calendar/contract year, unless agreed to by both parties. However, if a change in this Agreement is required due to a change in statute or regulation or in cases of fraud or misrepresentation, if the member is HIPAA eligible, and GHP reasonably believes the change increases GHP's risk under this Agreement, GHP may change the schedule of Premium payments upon 30 days written notice.

Any newborn of the Member who is covered under this individual policy, and for whom an application is submitted within the first thirty-one (31) days of birth, will be issued a policy at the standard rates without regard to medical risk.

IV. RESPONSIBILITIES OF MEMBER
Member agrees to: (1) Pay Premium payments to GHP in full via automatic withdrawal as drawn on the 10th calendar/business day of every month; (2) Furnish to GHP such information as may reasonably be required by GHP for the administration of coverage provided hereunder, including but not limited to name change, changes in banking information, address change, and any change(s) in the Member's eligibility status.

V. TERMINATION / REINSTATEMENT
Conditions for Termination under this Agreement by GHP and by the Member shall be determined in accordance with the Termination of Coverage Section of the COC. Termination includes, but is not limited to, the following reasons: (1) Upon written notice for fraud or material misrepresentation of information on this Enrollment Application/Change Form; (2) Upon written notice, if any payment required by the Member is not received by the Premium Due Date, subject to the 31-day Grace Period; (3) Upon 31 days prior written notice in the event that the Member fails to meet eligibility guidelines as defined in the COC. If upon a Member becoming ineligible, Member fails to notify GHP of such Member's ineligibility and Member has made or continues to make the Premium payments specified herein for such Member, such Premium payment(s) will be credited by GHP to Member, provided Member gives GHP notice of the ineligibility no later than 31 days after the date of eligibility ceased. (4) Upon written notice by the member requesting termination, policy will term at the end of the month requested.

For the purpose of this Section, "Reinstatement" means: Member's request to GHP that GHP provide coverage to Member after GHP's termination of the Agreement pursuant to this section and Member's payment to GHP of any Premiums due or cost for services.

In the event that Member requests Reinstatement after Member's Termination pursuant to this section, GHP may require a Reinstatement Fee of $500.00 and will require Member's written acknowledgment to GHP that the previously terminated Agreement is reinstated on the effective date of reinstatement GHP provides to Member.

VI. INCONSISTENCY
In the event of any inconsistency between this Enrollment Agreement and the COC, upon determination of the provision which contains a more favorable resolution as to the Member, that section shall prevail.

I agree that I have read the above Enrollment Agreement and agree to the terms and agreements.

For PPO applicants: (1) I apply for membership in this plan, underwritten by Coventry Health and Life Insurance Company (CH&L) and administered by Group Health Plan, Inc. (GHP).

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

If applicant is under the age of 18, this application must be signed by the applicant's parent or legal guardian.

*Applicant's Signature*_____ *Date*_____ *Relationship* _____ *(If signed by someone other than the applicant.)*

*Applicant Spouse's Signature*_____ *Date*_____

*Applicant's Signature*_____ *Date*_____
Dependent Age 18 or Older

*Applicant's Signature*_____ *Date*_____
Dependent Age 18 or Older

*Applicant's Signature*_____ *Date*_____
Dependent Age 18 or Older