❑New Enrollment ❑Change Form

HealthAmerica *One*™ Application

PPO Plan for HealthAmerica Ohio Insurance Trust underwritten by Coventry Health and Life Insurance Company

IMPORTANT: ALL FIELDS ON THIS FORM MUST BE COMPLETED FOR TIMELY PROCESSING.

	INDIVIDUAL INFORMATION (To Be Completed By Applicant)						
LAST NAME	FIRST NAME	MI	M/ F	BIRTHDATE	SOCIAL SECURITY NO.	MARITAL STATUS ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ SEPARATED ☐ DIVORCED	COVERAGE TYPE ☐ SINGLE ☐ FAMILY
ADDRESS		Employer		BUSINESS PHONE ( ) -			
CITY	STATE	ZIP CODE	Occupation/Title	HOME PHONE ( ) -	Benefit Selection		

B FAMILY MEMBERS TO BE COVERED OR DELETED

Full Name (Last, First, MI)	Gender	Relationship	Birthdate	Student or Disabled Dependent	SS Number	Height	Weight	Tobacco Use Yes/No
	M / F	**SELF**	/ /	-------	- -			
	M / F	SPOUSE	/ /	-------	- -			
	M / F		/ /	S / D	- -			
	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? ❑ YES ❑ NO

IF Yes, Please list the children.

CHILD'S NAME	RESPONSIBLE PARTY
1. ______________________	______________________
2. ______________________	______________________
3. ______________________	______________________
4. ______________________	______________________

C OTHER HEALTH INSURANCE

Do you or any of your dependents/spouse have other health coverage? ☐ No ☐ Yes – Complete Section Below

List all family members covered under other Health Insurance.

Policyholder	Birthdate / /	Name of Insurance Company	Contract #./Group #..	Policy eff date / /
List Names of all individuals covered				
Do you or any of your dependents have Medicare coverage? ☐ **No** ☐ **Yes – Continue below**				
Name	**If you have Medicare coverage you are not eligible to apply for HealthAmericaOne coverage**			
Name	**If you have Medicare coverage you are not eligible to apply for HealthAmericaOne coverage**			

D HEALTH HISTORY

This is the health history of you and your family members who you wish to cover under HealthAmericaOne coverage. Has any person listed on this application in the past five (5) years had, consulted or sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions? (Please answer Yes or No. Incomplete applications will be returned to you for completion.)

Condition	Yes No	Condition	Yes No
1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins, or any other disorder of the heart, blood, blood vessels, hyperlipidemia, or arteriosclerosis, high cholesterol or diabetes?	Yes ❑ No ❑	9. Any immune deficiency disorder, HIV, AIDS, or AIDS-related complex?	Yes ❑ No ❑
2. Ulcer, colitis, gall stone, hernia or any other disorder of the stomach, intestines, rectum, gall bladder, or liver?	Yes ❑ No ❑	10. Within the last five years, had an X-ray, electrocardiogram, cardiac catheterization, or any laboratory test or study?	Yes ❑ No ❑
3. Cancer, cyst or tumor?	Yes ❑ No ❑	11. Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner?	Yes ❑ No ❑
4. Disorder of the kidneys, blood or albumin, hemophilia, thyroid glands, venereal disease or any related eye disorders, urinary systems, male or female organs or menstrual dysfunction?	Yes ❑ No ❑	12. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same?	Yes ❑ No ❑
5. Tuberculosis, asthma, hay fever, adenoidectomy, pleurisy or any other kind of disorder of the lungs or respiratory system?	Yes ❑ No ❑	13. Is any female to be covered currently pregnant? If Yes, this disqualifies the individual for coverage.	Yes ❑ No ❑
6. Epilepsy, fainting spells, mental or nervous condition, paralysis or any other disorder of the brain or nervous system? If epileptic, date of last seizure:	Yes ❑ No ❑	14. Is any male listed on this application expecting a child with anyone, even if the mother is not listed on the application?	Yes ❑ No ❑
7. Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles or bones?	Yes ❑ No ❑	15. Any history of pregnancy complications?	Yes ❑ No ❑
8. Any serious bodily injury, fracture, concussion, burn and/or congenital problems?	Yes ❑ No ❑	16. Do you use tobacco products? If Yes, what kind? Frequency	Yes ❑ No ❑

Tell us about any other disease or condition not listed.

Please describe any holistic, alternative or natural treatment or remedies, in the past twelve (12) months.

Please list any medication you are currently taking

Name	Dosage	Prescribing Physician

If you answered "Yes" to any of the previous medical questions, you must complete the requested information about those conditions. Please explain and provide us FULL DETAILS for each "Yes" answer to any condition(s) checked in the proceeding boxes. Please give details on the last doctor visit and/or physical examination for ALL family members listed regardless of date or reason. You may insert additional sheets if necessary.

Question #	Name of Family Member	Name of Hospital, Clinic or person providing care	Phone #
Date of Onset/Treatment(Month/Year) Date Ended Still Under Treatment Y/N		Address	Suite #
Name of Condition(s) /Illness Treated		City, State, Zip Code	
Treatment Rendered		Medication (if taken)/ Date Prescribed Dosage	
Blood Pressure: #1 #2 #3 Blood Sugar: #1 #2 #3 Cholesterol: #1 #2 #3			

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CONDITIONS OF ENROLLMENT

I REPRESENT THAT ALL INFORMATION SUPPLIED ON THIS FORM IS TRUE AND COMPLETE. I HEREBY AGREE TO ALL CONDITIONS OF ENROLLMENT SET FORTH IN THIS APPLICATION. IF THE APPLICANT IS AN UNDERAGE DEPENDENT, THE INDIVIDUAL SIGNING THE APPLICATION MUST BE THE RESPONSIBLE PARTY FOR PREMIUM WITH THE AUTHORITY TO AGREE TO ALL CONDITIONS OF ENROLLMENT AND CONSENT TO THE RELEASE OF INFORMATION SET FORTH IN THIS APPLICATION.

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 PURPOSE 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.

Applicant's Signature____ Date____________________

AS THE APPLICANT I AGREE ALL INFORMATION ON THIS APPLICATION AND THE ATTACHED HEALTH QUESTIONNAIRE IS CORRECT AND TRUE. I UNDERSTAND THAT IT IS THE BASIS ON WHICH PREMIUM MAY BE DETERMINED UNDER THE COVERAGE. I UNDERSTAND THAT THE GROUP TRUST, HEALTHAMERICAONE, CONTRACT INCLUDES A PRE-EXISTING CONDITION EXCLUSION. 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 UNDER THE PPO COVERAGE I AM RESPONSIBLE FOR A GREATER PORTION OF THE COST OF MY COVERED MEDICAL COSTS WHEN I USE A NON-PARTICIPATING PROVIDER. I UNDERSTAND THAT UNDER THE PPO IF I OR ONE OF MY DEPENDENTS RECEIVE COVERED SERVICES FROM A NON-PARTICIPATING PROVIDER, MY HEALTHAMERICAONE CONTRACT 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 MY HEALTHAMERICAONE CONTRACT. I UNDERSTAND THAT SOME SERVICES MUST BE AUTHORIZED BY COVENTRY HEALTH AND LIFE INSURANCE COMPANY.

I AGREE ON BEHALF OF MYSELF AND THOSE FAMILY MEMBER ENROLLED IN THE HEALTH PLAN (DEPENDENTS), FOR WHOM I HAVE THE AUTHORITY TO ENROLL AND TO CONSENT ON THEIR BEHALF (COLLECTIVELY MY DEPENDENTS AND I SHALL BE REFERRED TO AS MY ENROLLED FAMILY) THAT COVENTRY HEALTH AND LIFE INSURANCE COMPANY MAY USE OR DISCLOSE TO THIRD PARTIES THE INFORMATION CONTAINED ON THIS ENROLLMENT FORM AND INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION RELATING TO MY ENROLLED FAMILY FOR PURPOSES OF ADMINISTERING MY HEALTH INSURANCE BENEFIT, INCLUDING FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS, AS THOSE TERMS ARE EXPLAINED IN DETAIL IN

COVENTRY HEALTH AND LIFE INSURANCE COMPANY NOTICE OF PRIVACY PRACTICES AND TO THE EXTENT PERMITTED BY LAW. MY ENROLLED FAMILY'S CONSENT INCLUDES AGREEMENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION THAT MAY INCLUDE DIAGNOSIS, PROGNOSIS, TREATMENT, AND PAYMENT INFORMATION RELATED TO PHYSICAL AND/OR MENTAL ILLNESS, INCLUDING SUBSTANCE ABUSE, AUTOIMMUNE DEFICIENCY SYNDROME (AIDS), AIDS RELATED COMPLEX (ARC), HUMAN IMMUNODEFICIENCY VIRUS (HIV).

F Premium Payment

Premiums due for your HealthAmericaOne coverage may only be paid from funds deducted directly from either your checking or saving account. This withdrawal is done with your authorization and approval for you and your family pending final medical underwriting and approved premium. To facilitate the monthly premium withdrawal we need your banking information. Please Provide ❏ Checking Account ❏ Savings Account

Name of Bank or Saving Institution______________________________

Bank Routing Number ______________________________

Your Account Number ______________________________

Address of Bank ______________________________

Name as it appears on the Account ______________________________

Address on the Account ______________________________

Date of 1st Transaction____________________ Frequency of Transaction: Monthly Monthly Transaction Date: 10th Day of each Month

Signature ______________________________

Date____________________

Providing this information does not guarantee coverage. Your policy/coverage will be in effect when the premium has been presented and accepted, medical underwriting completed and approved, and premium received and applied to your account. A VOIDED CHECK OR DEPOSIT SLIP MUST BE ATTACHED FOR PROCESSING.

G Application Completion

If you received assistance completing this application, please list the person or insurance producer who did so.

Name of Broker ____________________ Broker License's Number ____________________

Signature of Broker ____________________ Name of Agency Representing Broker ____________________