

**Application for Coventry Individual Health Insurance**

Aetna Health Inc., DBA Coventry Health Care of Georgia, Inc.

Primary Applicant's Name
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Applicant's Social Security Number

**INSTRUCTIONS:**

- Complete in blue or black ink only.
- PRINT clearly.
- All answers must be complete and truthful.

**IMPORTANT NOTES:**

- The information you provide is confidential.
- Intentional misrepresentation may result in the policy being modified or terminated.
- Proof of state residency may be required.
- **YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.**

**Section A – Primary Applicant Information (for parent/guardian for Child-Only application)**

Primary Applicant Last Name		First Name		Middle Initial
Home Address (No PO Boxes)				Apt. Number
City	State	ZIP Code	County	
Relationship (If Child-Only Application)				
Mailing Address (If different from your Home address)				
City			State	ZIP Code
Email Address				
Telephone Number		If we need to call you with questions about your application, when is the best time to reach you?		
Home	( )	<input type="checkbox"/>	Morning	<input type="checkbox"/>
Work	( )	<input type="checkbox"/>	Afternoon	<input type="checkbox"/>
Mobile	( )	<input type="checkbox"/>	Evening	

**Section B – Application Type**

Application Type (Select one):	
<input type="checkbox"/> New medical coverage	<input type="checkbox"/> Child-Only Application (Children up to age 21)
<input type="checkbox"/> Change current coverage	<input type="checkbox"/> Add dependent(s) to current coverage
<b>Your Effective Date will be assigned by Coventry, based on the receipt date of your application.</b>	

Primary Applicant's Name

**Section C – Enrollment Period**

**Annual Open Enrollment Period** (Annual period to enroll in medical coverage if no Special Enrollment Period applies. If you qualify for a Special Enrollment Period during the Annual Open Enrollment Period, coverage may start sooner.)

**Special Enrollment Period** (If you qualify for a Special Enrollment Period, you can enroll in medical coverage outside the Annual Open Enrollment Period. If you qualify for a Special Enrollment Period during the Annual Open Enrollment Period, coverage may start sooner.)

**If one of the events listed below applies to you, check the appropriate box.**

**The Special Open Enrollment Period for the following events begins 60 days prior to the date of the event checked and continues for 60 days after.**

Date of Event	Event
_____	<input type="checkbox"/> Loss of employer coverage due to termination of employment, reduction in hours, coverage no longer offered to my employment class, or expiration of COBRA coverage.
_____	<input type="checkbox"/> Loss of employer or individual coverage because no longer eligible as a dependent.
_____	<input type="checkbox"/> Loss of employer or individual coverage because of divorce from policyholder, death of policyholder, or policyholder enrolled in Medicare.
_____	<input type="checkbox"/> Loss of Medicaid or CHIP coverage.
_____	<input type="checkbox"/> Coverage needed following loss of eligibility for Exchange subsidies.
_____	<input type="checkbox"/> A permanent move.

**The Special Open Enrollment Period for the following events begins on the date of the event checked and continues for 60 days.**

_____	<input type="checkbox"/> Coverage needed for new dependent through marriage.
_____	<input type="checkbox"/> Coverage needed for new dependent through birth, adoption or placement for adoption.
_____	<input type="checkbox"/> Other, please explain. _____

**Section D – Coverage Selection**

**Choose the plan that best meets your needs.**

Bronze:	Silver:
<b>HMO Plans</b>	
<b>Atlanta HMO</b> Available in the following counties: Barrow, Cherokee, Clarke, Dawson, DeKalb, Forsyth, Fulton, Gwinnett, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Rockdale	
	<input type="checkbox"/> Coventry Silver \$15 Copay HMO Atlanta PD
<b>Augusta HMO</b> Available in the following counties: Columbia, Jefferson, Lincoln, McDuffie, Richmond	
	<input type="checkbox"/> Coventry Silver \$15 Copay HMO Augusta PD
<b>Columbus HMO</b> Available in the following counties: Chattahoochee, Harris, Marion, Muscogee, Stewart	
	<input type="checkbox"/> Coventry Silver \$15 Copay HMO Columbus PD
<b>Hall HMO</b> Available in the following counties: Hall, Jackson	
	<input type="checkbox"/> Coventry Silver \$15 Copay HMO Hall PD
<b>Macon HMO</b> Available in the following counties: Bibb, Bleckley, Crawford, Dodge, Dooly, Houston, Jones, Monroe, Peach, Pulaski, Putman, Twiggs	
	<input type="checkbox"/> Coventry Silver \$15 Copay HMO Macon PD
<b>Savannah HMO</b> Available in the following counties: Chatham	
	<input type="checkbox"/> Coventry Silver \$15 Copay HMO Savannah PD
<b>SEGA HMO</b> Available in the following counties: Appling, Brantley, Bryan, Camden, Charlton, Glynn, Jeff Davis, Liberty, McIntosh, Montgomery, Toombs, Treutlen, Wayne	
	<input type="checkbox"/> Coventry Silver \$15 Copay HMO SEGA PD
<b>SOGA HMO</b> Available in the following counties: Baker, Burke, Coffee, Crisp, Dougherty, Effingham, Emanuel, Evans, Lee, Long, Sumter, Terrell, Worth	
	<input type="checkbox"/> Coventry Silver \$15 Copay HMO SOGA PD
<b>Valdosta HMO</b> Available in the following counties: Berrien, Clinch, Colquitt, Echols, Lanier, Lowndes	
	<input type="checkbox"/> Coventry Silver \$15 Copay HMO Valdosta PD
<b>POS Plans</b> Not available in counties listed above	
<input type="checkbox"/> Coventry Bronze HSA Eligible POS PD	
<b>Health Savings Account (HSA)</b> If you have selected an HSA Eligible plan, you are eligible to open a Health Savings Account (HSA) through our HSA trustee, HealthEquity. After enrollment, you will receive information from HealthEquity with instructions to set up your HSA account.	

Primary Applicant's Name
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**Section E – Persons Requesting Coverage**

List all family members you wish to be covered under this policy.

Dependent children are eligible up to age 26.

**For a Child-Only application, start listing children at Child 1, with the youngest child listed first.**

Check here if you need more space to provide information for additional dependents. Use a separate sheet of paper and staple to the back of this application.

**If any person has regularly used tobacco products (cigarettes, pipe, cigars, snuff, or chewing tobacco) within the last six (6) months, check “Yes” as Tobacco User below (This does not apply to applicants under the age of 18). Regular use means an average of four or more times per week.**

**If any person uses tobacco for religious or ceremonial purposes only, check “No” for Tobacco User below.**

If choosing an HMO product, enter the Primary Care Physician (PCP) name and ID Number. Primary Care Physician (PCP) refers to the provider that you would see first for any medical problem. The PCP must be within our provider network. A list of participating providers can be found at [www.coventryone.com](http://www.coventryone.com) by selecting the Find a Doctor link. Please note that choice of PCP is not guaranteed; however, you can change your PCP at any time.

Primary Applicant Name (Last, First, Middle Initial)				Social Security Number
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Date of Birth (MM/DD/YYYY)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco User <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP Name _____ PCP ID Number _____
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Spouse/Domestic Partner Name (Last, First, Middle Initial)				Social Security Number
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Date of Birth (MM/DD/YYYY)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco User <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP Name _____ PCP ID Number _____
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Child 1 Name (Last, First, Middle Initial)				Social Security Number
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Date of Birth (MM/DD/YYYY)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco User <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP Name _____ PCP ID Number _____
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Child 2 Name (Last, First, Middle Initial)				Social Security Number
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Date of Birth (MM/DD/YYYY)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco User <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP Name _____ PCP ID Number _____
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Child 3 Name (Last, First, Middle Initial)				Social Security Number
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Date of Birth (MM/DD/YYYY)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco User <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP Name _____ PCP ID Number _____
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Child 4 Name (Last, First, Middle Initial)				Social Security Number
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Date of Birth (MM/DD/YYYY)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco User <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP Name _____ PCP ID Number _____
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Child 5 Name (Last, First, Middle Initial)				Social Security Number
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Date of Birth (MM/DD/YYYY)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco User <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP Name _____ PCP ID Number _____
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*continued*

Primary Applicant's Name

**Section E – Persons Requesting Coverage (Continued)**

**To be completed by the Primary Applicant**

Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Single		Are you a resident of the state in which you are applying? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How would you like Coventry to communicate with you regarding your application and coverage? <input type="checkbox"/> Email <input type="checkbox"/> Mail		Would you like to receive emails from us regarding your benefits, programs and general health information? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you like to turn off paper? <input type="checkbox"/> Yes <input type="checkbox"/> No If you turn off paper, we will send you emails about your claims and other activity on your account. You can also view your statements and communications online. Please note that there may be state or federal regulations that prohibit us from communicating with you in your preferred method.			
Are any applicants enrolled in or entitled to Medicare benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide name(s) of these applicants: _____			
Are all applicants listed on this application Citizens of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," provide Name and most recent date of arrival in the U.S. <b>Proof of state residency will be required.</b>			
Name		Most recent arrival date	
_____		_____	
_____		_____	
_____		_____	
Do you read and write English? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", you must complete the Statement of Accountability.) If "No," Primary Spoken Language: _____ Primary Written Language: _____			
Did you complete this application? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", you must complete the Statement of Accountability.)			
<b>Statement of Accountability – Must be completed if the applicant answered "No" to read or write English or the applicant did not complete this application.</b>			
I _____, acting as (describe your relationship) _____ have personally read this form to the applicant and completed the application because: <input type="checkbox"/> Applicant does not have sufficient command of the English language to complete this application <input type="checkbox"/> Applicant is legally incapacitated and unable to complete this application I have read and explained in detail the contents of this application.			
If translated, I also fully explained to the applicant the "Authorization to Disclose Personal Health Information" and "Signature(s) Required" under <b>Sections F and H.</b>			
Signature of Representative ( <b>Required</b> )			Today's Date ( <b>Required</b> )
Print Name			
Street Address			
City	State	ZIP Code	Telephone Number (    )

Primary Applicant's Name

**Section F – Authorization to Use and Disclose Protected Health Information**

**Please read the following carefully before completing your authorization. You may refuse to sign this authorization.**

**Purposes of this Authorization Form**

By signing this form, I authorize Coventry, or Coventry's representatives, to pay a fee to a third party for certain protected health information (PHI) about me, including but not limited to, prescribed medication history or other pharmaceutical information, hospital records, physician and/or dentist records, claims or benefit records or lab results. The PHI purchased by Coventry may be used for the following purposes: a) to coordinate medical care and case management, and/or b) for risk adjustment activities.

PHI purchased by Coventry may be related to chronic diseases, mental illness, alcohol or substance abuse, Human Immunodeficiency Virus (HIV) infection, or Acquired Immune Deficiency Syndrome (AIDS).

I authorize Coventry to disclose my PHI for the purposes stated above to other persons or organizations performing services on Coventry's behalf.

Coventry may not condition your treatment, payment, enrollment or eligibility for benefits, on whether or not you sign this authorization.

Coventry may not condition your treatment, payment, enrollment or eligibility for benefits, on whether or not you sign this authorization.

Health information received by Coventry will not be re-disclosed without your authorization unless permitted by law, as described in Coventry's Notice of Privacy Practices. Information that is re-disclosed may not be protected under federal privacy laws.

**Term of Authorization**

I agree this Authorization shall be valid for eighteen (18) months from the signature date below.

**Right to Revoke**

I understand that I may revoke this authorization at any time by giving written notice to Coventry using the address provided in Section J. My revocation will not have any effect on actions Coventry has already taken before receiving my notice.

<b>Primary Applicant's or Parent/Guardian's Signature</b>	Date
<b>Spouse / Domestic Partner's Signature</b>	Date
<b>Dependent's signature (age 18 or older)</b>	Date
<b>Dependent's signature (age 18 or older)</b>	Date

Primary Applicant's Name

**Section G – Payment Options (Select the method of payment for your initial application and following premium payments.)**

**Initial Payment**

Electronic Fund Transfer (complete the EFT information below)  
 Monthly Billing Statement

**Recurring or Follow Up Payments**

Electronic Fund Transfer (complete the EFT information below)  
 Monthly Billing Statement

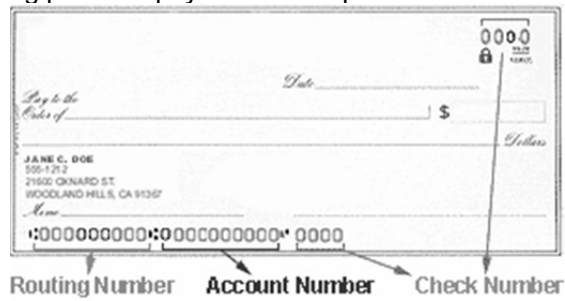
**Payroll Deduction Program (PDP) / Employer List Bill (ELB)**

This program allows your premium to be deducted directly from your paycheck, on a post-tax basis. Other details apply. To choose this option, you MUST submit a separate Payroll Deduction Authorization Form with your application.  
 New Payroll Deduction Program (PDP) / Employer List Bill (ELB)  
 Existing Payroll Deduction Program (PDP) / Employer List Bill (ELB)  
ELB Number: \_\_\_\_\_  
ELB Name: \_\_\_\_\_

**Electronic Fund Transfer – EFT**

Upon issuance, the first month's premium will automatically be withdrawn from the listed bank account. The following monthly premiums will be withdrawn automatically from the bank account listed on the application on the 5th day (or the following business day if a weekend or holiday) in the month for which premium is due. The premium amount due is calculated per day, so if the effective date is anything other than the 1st of the month, the following premium payment will be prorated.

Account Number: \_\_\_\_\_  
Routing Number:   
Token: \_\_\_\_\_  
Name(s) on Account: \_\_\_\_\_  
Account Holder Address: \_\_\_\_\_  
 Checking  Savings



**Any rate adjustment made in accordance with the enrollment process will be automatically charged to your account upon approval of your application. Please be advised that tobacco use may result in an increase to the standard premium.**

**Important Note:** CoventryOne is not an employer-sponsored group health plan. If your banking information is from a business account, or you are submitting a check drawn from a business account, you must contact us / your agent to complete a CoventryOne Payroll Deduction / Employer List Bill (ELB) Authorization Form.

- By signing this Premium Payment section, you are agreeing to the following statements:
- You understand that it is your responsibility to immediately notify Coventry at 1-866-364-5663 should your payment or address information change at any time while you continue to hold a CoventryOne policy.
  - Failure to remit the first payment could result in rescission back to your effective date.
  - You understand that providing this payment information does not guarantee approval for coverage.
  - Upon issuance of this Application, you authorize Coventry to initiate an immediate automatic withdrawal and / or a billing cycle of applicable premium payments from your provided account or billing information. If your effective date is entered into the system after the third business day of the month, your following automatic withdrawal may include premium amounts for multiple months.
  - I agree this authorization will remain in effect until I provide written notification terminating this service.

<b>Account / Card Holder Signature</b>	<b>Date</b>
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Primary Applicant's Name

**Section H – Signature(s) Required – All Applicants (Primary/Spouse and dependents) age 18 and older must read and sign this form below.**

**By signing this form you agree to the following:**

1. The answers in this application are true and complete to the best of my knowledge and belief.
2. The children listed on this application are my legal dependents.
3. I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by Coventry, and may face legal liability, including legal action based on fraud.
4. I have read this entire application, or it has been read to me.
5. The information I have provided in this application will be used by Coventry to determine whether to issue coverage and the premium amount for such coverage.
6. No coverage shall be in force until Coventry processes this application and Coventry has notified me of my effective date.
7. This application will become part of the contract between Coventry and me.
8. I or my legal representative has the right to receive a copy of this application upon request. I agree that a photocopy shall be as valid as the original. A legal facsimile signature shall have the same force and effect as the original.
9. I authorize Coventry to electronically transmit the information contained in this application.

<b>Primary Applicant's or Parent/Guardian's Signature</b>	Date
<b>Spouse / Domestic Partner's Signature</b>	Date
<b>Dependent's signature (age 18 or older)</b>	Date
<b>Dependent's signature (age 18 or older)</b>	Date

Primary Applicant's Name

**Section I – Insurance Producer or Agent (Required If Applicable)**

**Complete if Broker of Record is an Individual Producer (not an Agency)**

Print Name of Producer	NPN of Agent	
Signature of Producer (required if applicable)	Telephone Number (     )	
Email Address	Fax Number (     )	
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)		

**Complete if Broker of Record is an Agency**

Name of Agency	TIN of Agency	
Email Address	Telephone Number (     )	Fax Number (     )
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)		
Print Name of Producer Representing Agency	NPN Number	
Signature of Agency Representative (required if applicable)		

**General Agent**

Print Name of General Agent	TIN of General Agent
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	

**Coventry Sales Representative**

Last Name of Agent (Print Name)	First Name of Agent (Print Name)	License Number
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**Section J – Contact Information**

Please return this application to the agent or submit to the address listed below.	
<b>Coventry Individual Plans</b>	<b>Fax #: 877-904-7822</b>
<b>PO Box 31217</b>	<b>Email: <a href="mailto:cvtynewapps@healthplan.com">cvtynewapps@healthplan.com</a></b>
<b>Tampa, FL 33631-3217</b>	<b>Website for information: <a href="http://www.coventryone.com">www.coventryone.com</a></b>



Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call (855) 208-4606.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,  
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),  
1-800-648-7817, TTY: 711,  
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).*

TTY: 711

For language assistance in English call 855.208.4606 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 855.208.4606. (Spanish)

欲取得繁體中文語言協助，請撥打 855.208.4606，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 855.208.4606 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 855.208.4606 nang walang bayad. (Tagalog)

T'áá shí shizaad k'ehjí bee shíká a'doowoł nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 855.208.4606 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 855.208.4606 an. (German)

በ አገልግሎት የደንበኞች አገዛዝ ለማግኘት በ 855.208.4606 በነጻ ይደውሉ (Amharic)

لمساعدة في اللغة العربية (اللائحة) على الرقم المجدي 855.208.4606 (Acj ak\*)

Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 855.208.4606 ku busa. (Bantu-Kirundi)

বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 855.208.4606-তে কল করুন। (Bengali-Bangala)

ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 855.208.4606 ကို ခေါ်ဆိုပါ။ (Burmese)

ᎠᎵᏍᎦᎵ ᎠᎵᏍᎦᎵ ᎠᎵᏍᎦᎵ (GW) ᎠᎵᏍᎦᎵ 855.208.4606 ᎠᎵᏍᎦᎵ ᎠᎵᏍᎦᎵ (Cherokee)

Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 855.208.4606 irratti bilisaan bilbilaa. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 855.208.4606. (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 855.208.4606 gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 855.208.4606 χωρίς χρέωση. (Greek)

(Gujarati) ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 855.208.4606 પર કોલ કરો.

(Hindi) हिन्दी में भाषा सहायता के लिए, 855.208.4606 पर मुफ्त कॉल करें।



Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 855.208.4606. Njodi woo fawaaki on. (Sudanic-Fulfulde)

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 855.208.4606 bila malipo. (Swahili)

ܡܢ ܕܒܠܘܢ ܘܥܪܘܩܝܐ ܘܟܪܕܘܬܐ ܘܗܗܘܐ ܡܢ ܕܡܪܝܢ

(Syriac-Assyrian) ܘܡܬܢ ܡܪܝܢ ܨܘܢܝܘܬܐ ܘܚܘܫܘܬܐ ܘܟܪܕܘܬܐ ܘܗܗܘܐ ܡܢ ܕܡܪܝܢ 855.208.4606

భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 855.208.4606కు కాల్ చేయండి. (తెలుగు) (Telugu)

สำหรับความช่วยเหลือทางคำานภาษาเป็นภาษาไทย โทร 855.208.4606 ฟรีไม่มีค่าใช้จ่าย (Thai)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 855.208.4606. (Ukrainian)

(Urdu) ۸۵۵.۲۰۸.۴۶۰۶ کے لئے ۲۰۲۳-۲۰۲۴ کیلئے یوٹی بی سی کے ذریعے

Để được hỗ trợ ngôn ngữ b ng (ngôn ngữ , hã gọi miễn phí đến số 855.208.4606. (Vietnamese)

פאר שפראך הילף אין אידיש רופט 855.208.4606 פון אפצאל . )Yiddish\*

Fún ìrànṣọ̀wọ̀ nípa èdè (Yorùbá) pe 855.208.4606 láí san owó kankan rára. (Yoruba)