



# Enrollment/Change Form

## Instruction Sheet

**P**lease detach this instruction sheet and place it beside your Enrollment/Change Form to assist you in the proper completion of the form. **You must complete Sections, A, B, C, & D completely** when enrolling, adding, or deleting a dependent. After completing and signing the form, discard this sheet and return the form to your employer. Your employer will then verify that all information given is correct and return the employee copy to you. **Please keep the blue copy for your records. If newly enrolling, your copy is to be used as your temporary I.D. card until your membership card arrives.**

### FOLLOW STEPS 1 THROUGH 4:

**1** Please provide all information requested.

**2** Be sure to complete the full name, sex, relationship to you, date of birth, social security number, and PCP's name and PCP ID for you and each family member you are enrolling. **Dependents not listed will not be covered.** Circle (S) if full time student or (D) if physically disabled. \*If change only, list only the dependent(s) that you are adding or deleting.

**3 Very Important.** Fill in Section C completely to ensure efficient service.

**4 Read the back of your enrollment form.** Sign and date the form before returning it to your employer.



# ENROLLMENT/CHANGE FORM

## A TO BE COMPLETED BY EMPLOYEE

LAST NAME	FIRST NAME	MI	M/F	BIRTH DATE / /	SOCIAL SECURITY NO. - -	<b>COVERAGE TYPE</b> <input type="checkbox"/> SINGLE <input type="checkbox"/> PARENT/CHILD <input type="checkbox"/> FAMILY <input type="checkbox"/> PARENT/CHILDREN <input type="checkbox"/> HUSBAND/WIFE	<b>MARITAL STATUS</b> <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED (Date) _____ <input type="checkbox"/> DIVORCED (Date) _____ <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED
ADDRESS			PRIMARY CARE PHYSICIAN / PCP ID		WORK PHONE ( ) -		
CITY	STATE	ZIP CODE	COUNTY		HOME PHONE ( ) -	<b>DATE OF HIRE</b> _____ <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED	

## B FAMILY MEMBERS TO BE ENROLLED OR DELETED

ENROLL OR DELETE	FULL NAME (LAST, FIRST, MI)	SEX	RELATIONSHIP	BIRTH DATE	STUDENT OR DISABLED	SOCIAL SECURITY NO.	PRIMARY CARE PHYSICIAN (PCP)	PCP ID
E D		M / F	Spouse	/ /	_____	- -		
E D		M / F		/ /	S / D	- -		
E D		M / F		/ /	S / D	- -		
E D		M / F		/ /	S / D	- -		
E D		M / F		/ /	S / D	- -		
E D		M / F		/ /	S / D	- -		

## C OTHER INSURANCE

Do you or your dependents have other coverage? No \_\_\_\_\_ If Yes complete the following:

List all family members with medical health insurance in addition to Coventry Health Care of Georgia

POLICY HOLDER	BIRTH DATE / /	EMPLOYER	INSURANCE COMPANY
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LIST DEPENDENTS COVERED	EFF. DATE / /	CONTRACT NO./GROUP NO.
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Do you or your dependents have Medicare Coverage? \_\_\_\_\_ Yes \_\_\_\_\_ No If Yes, please complete the following:

NAME	MEDICARE ID NO.	PART A EFF. DATE	PART B EFF. DATE
NAME	MEDICARE ID NO.	PART A EFF. DATE	PART B EFF. DATE

## D PLAN: (Please Circle One) GOLD VALUE PREMIERE MAX CHOICE PREMIERE PLUS FLEX OPTION PLAN

\_\_\_\_\_  
 EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## E EMPLOYER INFORMATION (To Be Completed By Employer)

GROUP NO.	GROUP NAME	EFFECTIVE DATE / /	EMPLOYER'S SIGNATURE	DATE / /
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<b>ENROLL</b> <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> NEW HIRE <input type="checkbox"/> REINSTATE	<input type="checkbox"/> COBRA <input type="checkbox"/> DIRECT PAY <input type="checkbox"/> OTHER _____	<b>CHANGE</b> <input type="checkbox"/> ADD DEPENDENT (reason for addition) _____ <input type="checkbox"/> DELETE DEPENDENT (reason for deletion) _____ <input type="checkbox"/> ADDRESS CHANGE	<input type="checkbox"/> CANCEL COVERAGE (reason) _____ <input type="checkbox"/> NAME CHANGE PREVIOUS NAME _____
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**IMPORTANT: ALL FIELDS ON THIS FORM MUST BE COMPLETED FOR TIMELY PROCESSING.** (TO BE COMPLETED BY CHC OF GEORGIA)  
 DATE RECEIVED \_\_\_\_\_

SEE REVERSE SIDE FOR CONDITIONS OF ENROLLMENT.

WHITE-CHC, CANARY-Company, BLUE-Member (Please keep this as your temporary ID until you receive your ID cards.)

## CONDITIONS OF ENROLLMENT

1. **I hereby enroll for benefits for the person(s) listed, and agree that I and my family members shall abide by the provisions of coverage set forth in the Group Contract under which we are enrolled.**
2. **I understand** that the Group Contract will determine the rights and responsibilities of Member(s) and Coventry Health Care of Georgia and will govern in the event of conflict with other materials provided by my employer or Coventry Health Care of Georgia.
3. **I understand** that any material misrepresentation in answering the questions on this application or nonpayment of premium or copayment(s) may result in termination of coverage.
4. **I understand** that the effective date of coverage shall be determined by my employer according to the guidelines established between my employer and Coventry Health Care of Georgia.
5. **I authorize** any physician, hospital, other medical provider, and persons or organizations involved in utilization review, peer review, and other plan administrative duties to disclose to Coventry Health Care of Georgia any medical information relating to the individuals specified on this application.
6. **I understand** that all covered medical services must be performed or authorized by the member's Primary Care Physician or Coventry Health Care of Georgia and be obtained from a participating provider unless otherwise authorized by Coventry Health Care of Georgia.
7. **I authorize** deductions from my earnings of the required contribution, if any, toward the cost of Coventry Health Care of Georgia coverage (if applicable).
8. **I understand** that it is my responsibility to report to my employer any changes in the eligibility of the individuals listed or any change to the information I have provided on this Enrollment Form.
9. **I understand** that enrollment is effective on acceptance by Coventry Health Care of Georgia and will remain in effect until the employer's next open enrollment period, regardless of the continued participation of a particular provider.
10. **I understand** that coverage and benefits are contingent upon prompt payment of premiums.
11. **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.**
12. **This managed care plan may not cover all your health care expenses. Read your Group Contract carefully to determine which health care services are covered. For questions, call 1-800-395-2545.**