APPLICATION AGREEMENT FOR INDIVIDUAL HEALTH INSURANCE

Check One
☐ New Enrollment ☐ Change Form

Mail: Coventry One
8320 Ward Parkway
Kansas City, MO 64114
Fax: (866) 560-6325

A APPLICANT(S) INFORMATION (To Be Completed By Applicant)

Last Name	First Name	MI	M/F	Birth Date	Social Security Number	REQUESTED EFFECTIVE DATE

Address	Employer	Occupation/Title	Business Phone	E-mail address
			( ) -	

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

DEPENDENT(S) INFORMATION (To Be Completed By Applicant)

Last Name, First Name, MI	Gender	Birth Date	Height	Weight	Social Security Number	Dependent Status	Out of Area	Resides with Applicant*
Spouse	o M o F					N/A	o Y o N	o Y o N
Child	o M o F					o Student o Disabled	o Y o N	o Y o N
Child	o M o F					o Student o Disabled	o Y o N	o Y o N
Child	o M o F					o Student o Disabled	o Y o N	o Y o N
Child	o M o F					o Student o Disabled	o Y o N	o Y o N
Child	o M o F					o Student o Disabled	o Y o N	o Y o N

*Coverage will not be offered to dependents living outside of the service area, unless they are a qualified Full-Time Student, or if coverage is required by a court decree. If you are subject to a court decree to provide health insurance coverage for any of the dependents listed above, please provide a copy of the decree. For disabled dependents, please provide a written description and proof of disability.

B OTHER HEALTH COVERAGE

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

Policyholder Name	Policyholder Birthdate	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

Applicant Last Name: ______________________ First Name: ______________________

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Administered by Coventry Health Care of Kansas, Inc.

C Benefit Selection – Please select the benefit plan for which you are requesting coverage.

Kansas Benefit Plans	Missouri Benefit Plans
☐ KI08C05020 20 ($500 Ded., 80%/60%)	☐ MI08C05020 20 ($500 Ded., 80%/60%)
☐ KI08C10025 20 ($1,000 Ded., 80%/60%)	☐ MI08C10025 20 ($1,000 Ded., 80%/60%)
☐ KI08C20040 25 ($2,000 Ded., 80%/60%)	☐ MI08C20040 25 ($2,000 Ded., 80%/60%)
☐ KI08C25045 25 ($2,500 Ded., 80%/60%)	☐ MI08C25045 25 ($2,500 Ded., 80%/60%)
☐ KI08C30050 30 ($3,000 Ded., 80%/60%)	☐ MI08C30050 30 ($3,000 Ded., 80%/60%)
☐ KI08C50075 99 ($5,000 Ded., 80%/60%)	☐ MI08C50075 99 ($5,000 Ded., 80%/60%)
☐ KI08C500150 99 ($5,000 Ded., 80%/60%)	☐ MI08C500150 99 ($5,000 Ded., 80%/60%)
☐ KI08F20040 99 ($2,000 Ded., 50%/30%)	☐ MI08F20040 99 ($2,000 Ded., 50%/30%)
☐ KIQ08A25025 30 ($2,500 Ded., 100%/80%)	☐ MIQ08A25025 30 ($2,500 Ded., 100%/80%)
☐ KIQ08A50050 20 ($5,000 Ded., 100%/80%)	☐ MIQ08A50050 20 ($5,000 Ded., 100%/80%)

Missouri Residents Only: Under HIPAA, if you are an "eligible individual", you have a right to buy certain individual health policies without pre-existing condition limitations. To be an eligible individual, you must meet the following requirements:

True	False	
☐	☐	You have had coverage for at least 18 months without a break in coverage of 63 days or more;
☐	☐	Your most recent coverage was under a group health plan, church plan or governmental plan (which can be demonstrated by a Certificate of Creditable Coverage or other evidence of prior coverage);
☐	☐	Your group coverage was not terminated because of fraud or nonpayment of premiums;
☐	☐	You are not eligible for or were not offered COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision);
☐	☐	You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

If you are a HIPAA eligible individual, you have a right to purchase a policy with no pre-existing condition limitations applied even if you have otherwise met the requirements of an underwritten health plan. Or if you do not qualify for an underwritten health plan due to health conditions, you may be offered one of our guarantee issue plans. Please note, the rates may be significantly higher for a policy with no pre-existing condition limitations or a guarantee issue policy than our underwritten policies or published rates. Failure to answer the questions under this section accurately may result in the loss of your rights as an eligible individual including the right to a guarantee issue policy and/or waiver of the pre-existing condition limitations. It is your responsibility to provide a certificate of creditable coverage, or other evidence of creditable coverage in order to determine your HIPAA eligibility.

D Premium Payment

Premiums due for coverage under this policy will be paid from funds deducted from either your checking or saving account. This withdrawal is done with your authorization and approval, pending final medical underwriting, an approved premium and your acceptance of coverage. To facilitate the monthly premium withdrawal we need your banking information. Providing this information does not guarantee coverage and no funds will be drawn prior to notification and acceptance by applicant.

Please Provide: ☐ Checking Account ☐ Savings Account

Name of Bank or Saving Institution: ____________________

Routing Number ____________________ Account Number ____________________

Address of Bank ____________________

Name that appears on the Account ____________________

Address on the Account ____________________

Frequency of Transaction: Monthly Transaction Date: 10th Day of each Month

NAME
ADDRESS
CITY, STATE ZIP
0123
01-2345/6789
DATE
PAY TO THE ORDER OF $
DOLLARS
BANK NAME
ADDRESS
CITY, STATE ZIP
FOR
⑆012345678⑆ 0123456789012⑈ 0123

Routing Number
Account Number

Your policy/coverage will be in effect when the premium rate has been presented and accepted, medical underwriting completed and approved, and premium payment received and applied to your account. By signing below, I authorize Coventry Health and Life Insurance Company to initiate automatic withdrawal of applicable premium payments from the account listed above. **I understand that it is my responsibility to notify the Plan if I change banks or account numbers.**

Accountholder Signature____________________Date____________________

Applicant Last Name: ____________________ First Name: ____________________

E HEALTH HISTORY

Please check Yes or No and provide details for all Yes answers below.

Within the past five (5) years have you, and/or any dependent included on this application, consulted or sought treatment, been diagnosed, had treatment recommended, received 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.

Question	Yes No	Question	Yes No
1. Heart attack, heart murmur, irregular heart rate, stroke, chest pain, high blood pressure, angioplasty, rheumatic fever, congestive heart failure, heart or valve disorder? If you answer yes, what is your current blood pressure: ______________	Yes ☐ No ☐	14. Have you, and/or any dependent included on this application, been treated in the emergency room, been hospitalized, or had surgery in the past 5 years?	Yes ☐ No ☐
2. Hyperlipidemia, high cholesterol, arteriosclerosis, circulatory or vascular problems, hemophilia, blood clots, anemia, blood vessels or bleeding disorder? If you answer yes, what is your total cholesterol : __________________	Yes ☐ No ☐	15. Manic depression, bipolar, panic attacks, schizophrenia, obsessive-compulsive disorder (OCD), depression, or behavioral disorder?	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 ☐	16. Cataracts, glaucoma, macular degeneration, retinopathy, strabismus, eye disorders, ear infections, ear disorder or hearing impairment?	Yes ☐ No ☐
4. Cancer, cyst, polyps, tumor or growth of any kind? Any skin irritation, infection, rash, or condition?	Yes ☐ No ☐	17. Thyroid, pituitary or adrenal gland disorder?	Yes ☐ No ☐
5. Disorder of the kidneys, prostate or urinary system, kidney failure, blood or albumin in urine, or receiving dialysis?	Yes ☐ No ☐	18. Sexually transmitted disease, abnormal pap smear or mammogram, breast disorder, disorder of male or female organs, or menstrual dysfunction?	Yes ☐ No ☐
6. Tuberculosis, emphysema, COPD, bronchitis, asthma, allergies, sleep apnea, pneumonia, pleurisy, or disorder of the lungs or respiratory system?	Yes ☐ No ☐	19. Currently taking prescription medication or receiving injection therapy?	Yes ☐ No ☐
7. Epilepsy, fainting spells, migraines, frequent headaches, attention deficit disorders, paralysis, brain, or neurological disorders? If epileptic, date of last seizure:	Yes ☐ No ☐	20. Are you or any family member pregnant or have a reason to suspect you or they are pregnant? Due date?__________ Whom?_____________	Yes ☐ No ☐
8. Lupus, fibromyalgia, arthritis, fractures, back or spinal conditions, or disorder of the joints, muscles or bones?	Yes ☐ No ☐	21. Been treated, counseled, or advised to seek treatment regarding use of alcohol, illegal substance, narcotics or prescription drugs?	Yes ☐ No ☐
9. Any bodily injury, concussion, burns, congenital problems or defects? Any chronic infections or infectious diseases?	Yes ☐ No ☐	22. Sought or been advised to seek psychiatric, psychological or mental health treatment, or counseling?	Yes ☐ No ☐
10. Diabetes or abnormal glucose test (high/low)? If diabetes, Type: _______ Any complications?	Yes ☐ No ☐	23. Anorexia, bulimia, gastric bypass, or other eating disorders?	Yes ☐ No ☐
11. Donor, recipient, or a candidate for a transplant? When? ________________	Yes ☐ No ☐	24. Had an X-ray, electrocardiogram, cardiac catheterization, MRI, CT scan, ultrasound or other diagnostic test or procedure?	Yes ☐ No ☐
12. Any amputations, prosthetic devices or implants?	Yes ☐ No ☐	25. Have you, and/or any dependent included on this application, used tobacco products in the past 12 months? If Yes, what kind? Frequency	Yes ☐ No ☐
13. Any immune deficiency disorder, HIV, AIDS, or AIDS-related complex?	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. Please describe any holistic, alternative, natural treatment, or remedies in the past twelve (12) months.

29. Please list any medication you, and/or any dependent included on this application, are currently taking, or have taken in the past 12 months, including injection therapy.

Applicant's Name	Name of medication	Dosage	Prescribing Physician

Applicant Last Name: ______________________________ First Name: ______________________________

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30. Name of 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 proceeding boxes. Please give details on the last doctor visit and/or physical examination regardless of date or reason. Insert additional sheets if necessary.

Question #	Applicant's Name	Condition or Diagnosis	Date of Onset/Treatment(Month/Year)	Date Ended	Still Under Treatment? Yes ☐ No ☐
Treatment Rendered			Medication (if taken)/ Date Prescribed/ Dosage		
Name of Hospital, Clinic or person providing care			Address		Phone #

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

Applicant Last Name: ______________________________ First Name: ______________________________

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F CONDITIONS OF ENROLLMENT

I agree on behalf of myself and/or my Dependents, to enroll and to consent that Coventry Health and Life Insurance Company or their authorized representatives (collectively referred to as "Health Plan") may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to me for purposes of administering my health insurance benefit, including for treatment, payment or health care operations, as those terms are explained in detail in Health Plan's Notice of Privacy Practices and to the extent permitted by law.

I also agree on behalf of myself and/or my Dependents, that, to the extent permitted by law, health care providers, insurers, claims administrators, employers and others may disclose my personal information including individually identifiable 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 related complex, human immunodeficiency virus or genetic conditions to Health Plan for Health Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law.

I represent on behalf of myself and/or my Dependents, that all information on this application form is complete and accurate to the best of my knowledge. I understand that my answers to the questions on this form will be used to determine eligibility for coverage and is the basis on which my premium rate may be determined. I further understand that if any information is omitted or misrepresented, it could provide the basis to refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force. After coverage has been in force for two years, no statement except fraudulent statements I make voids my coverage or reduces my benefits.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison

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.

G BROKER INFORMATION

Name of Broker ____ Signature of Broker ____

Phone Number ____ Email Address ____

Broker ID Number ____

Name of General Agent _____RW Evenson/ Bob Evenson_ Signature of General Agent _________________________________

Phone Number ___________785/266-9160___________________ Email Address ______rwevenson@aol.com__________

Office Use Only

Applicant Last Name: ____ First Name: ____

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