



GROUP ENROLLMENT & CHANGE FORM

Products are underwritten by Coventry Health Care of Missouri, Inc. ("Coventry Health Care") and/or Coventry Health and Life Insurance Co. 550 Maryville Centre Drive, Suite 300, St. Louis, MO 63141

Incomplete information may delay the processing of your enrollment and/or your member ID card.

EMPLOYER INFORMATION: To Be Completed By Employer

Company Name: **EAST MISSOURI ACTION AGENCY** Group No. (10 digits): **6378700000** Effective Date of Coverage: _____ Date: _____
 Reason for Enrollment: New Hire Open Enrollment Address/Phone Termination Reason & Date: _____
 Cobra Hardship Other: _____
 Reason for Change: Addition Coverage Termination Reason & Date: _____
 PGP Change Reason: _____
 Benefits Administrator Approval: _____

EMPLOYEE INFORMATION: To Be Completed By Employee

Last Name: _____ First Name: _____ MI: _____ Social Security Number: _____
 Street Address: _____ Work Phone & Area Code: _____
 City: _____ State: _____ Zip Code: _____ Home Phone & Area Code: _____
 Marital Status: Single Married Separated Divorced Widowed
 Product Selections (Please write in plan number):
 HMO: _____
 POS: _____
 Open Access HMO: _____
 Open Access POS: _____
 PPO: **CR3000**
 Carelink Select: _____
 IL Plus: _____
 Carelink from Coventry: _____

MEMBER INFORMATION: Family Members to be Covered and Physician Selection

All areas below must be filled out for each family member or it will delay processing enrollment. If "other" is checked, please indicate the nature of that relationship and include any appropriate legal documents. *Note: PPO and Sencicare members do not need to select a physician. For Carelink from Coventry plans, selecting a Primary Care Physician is required. *Attention Female Illinois Members: You may designate an IL OB-Gyn as your Women's Principal Health Care Provider (WPHCP), in addition to your Primary Care Physician (PCP). Please write your WPHCP choice in the box labeled OB-Gyn name.

Relationship	Add/ Delete	Last Name	First Name	M.I.	Social Security Number	Sex	Date of Birth	Primary Care Name and I.D. Number	Current Patient	*OB-GYN Name	Height/ Weight
<input type="checkbox"/> Self	<input type="checkbox"/> Add <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F	Month: _____ Day: _____ Year: _____	Name: _____ I.D. # _____	<input type="checkbox"/> Y <input type="checkbox"/> N		H: _____ W: _____
<input type="checkbox"/> Husband	<input type="checkbox"/> Add <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F		Name: _____ I.D. # _____	<input type="checkbox"/> Y <input type="checkbox"/> N		H: _____ W: _____
<input type="checkbox"/> Wife	<input type="checkbox"/> Add <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F		Name: _____ I.D. # _____	<input type="checkbox"/> Y <input type="checkbox"/> N		H: _____ W: _____
<input type="checkbox"/> Son	<input type="checkbox"/> Add <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F		Name: _____ I.D. # _____	<input type="checkbox"/> Y <input type="checkbox"/> N		H: _____ W: _____
<input type="checkbox"/> Daughter	<input type="checkbox"/> Add <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F		Name: _____ I.D. # _____	<input type="checkbox"/> Y <input type="checkbox"/> N		H: _____ W: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F		Name: _____ I.D. # _____	<input type="checkbox"/> Y <input type="checkbox"/> N		H: _____ W: _____
<input type="checkbox"/> Son	<input type="checkbox"/> Add <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F		Name: _____ I.D. # _____	<input type="checkbox"/> Y <input type="checkbox"/> N		H: _____ W: _____
<input type="checkbox"/> Daughter	<input type="checkbox"/> Add <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F		Name: _____ I.D. # _____	<input type="checkbox"/> Y <input type="checkbox"/> N		H: _____ W: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F		Name: _____ I.D. # _____	<input type="checkbox"/> Y <input type="checkbox"/> N		H: _____ W: _____

OTHER HEALTH INSURANCE INFORMATION: Complete or Write N/A

Name of Policyholder: _____ Bricate (mo/day/yr): _____ Social Security Number: _____
 Name of Employer: _____
 Name of Insurance Company of Health & Welfare Plan: _____ Insurance Company Phone Number: _____ Effective Date: _____
 Insurance Company Claim Address: _____ Insurance Policy Number: _____ Group Number: _____
 List of Family Members Covered: _____ Covered and on Medicare: _____ Medicare A Eff. Date: _____
 Medicare B Eff. Date: _____

AGREEMENT: Please read the following carefully.

- I apply for membership in or waiver of Coventry Health Care for myself and for any eligible dependents listed. If enrolled, I authorize my employer to make decisions, if any, toward the premium cost of Coventry Health Care.
- When enrolled, I and my eligible dependents shall abide by the provisions of coverage in the Group Enrollment Agreement, Certificate of Coverage and Benefit Riders under which we are enrolled.
- By signing this form, I authorize my employer, and any physician, hospital, medical group or other facility providing me care, treatment or consultation, to disclose to Coventry Health Care, or receive from Coventry Health Care, any medical or claim information pertaining to the persons identified in this enrollment form (receiving or applying for coverage under this plan, as may be necessary to provide Coventry Health Care to make coverage determinations, pay claims or otherwise administer plan programs, including without limitation, credentialing of physicians and as applicable, other providers, all of which shall be confidential in accordance with state and federal confidentiality laws. Coventry Health Care will not disclose any information pertaining to HMO/POS or chemical dependency/substance abuse except as specifically permitted by applicable law.
- I understand and agree to benefits shall take effect until this application is approved by Coventry Health Care.
- I understand that my membership may be cancelled for one or both of the following reasons: (1) failure to pay the amount due under the Group Enrollment Agreement or Certificate of Coverage, for which I am legally responsible, or (2) fraud or material misrepresentation in enrollment or in the use of services of facilities.
- I understand that it is my responsibility to report to Coventry Health Care any change in the eligibility of myself or my dependents.

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

Applicant's Signature: _____ Date: _____

1 HMO - underwritten by Coventry Health Care
 2 POS - HMO underwritten by Coventry Health Care - Out-of-Network underwritten by Coventry Health & Life Insurance Co.
 3 Open Access HMO - underwritten by Coventry Health Care
 4 Open Access POS - Benefits underwritten by Coventry Health & Life Insurance Co.
 5 PPO - underwritten by Coventry Health & Life Insurance Co.
 6 Carelink Select - underwritten by Coventry Health & Life Insurance Co.
 7 IL Plus - HMO underwritten by Coventry Health Care; Out-of-Network underwritten by Coventry Health & Life Insurance Co.
 8 Carelink from Coventry - PPO underwritten by Coventry Health and Life Insurance Company