



ENROLLMENT & CHANGE FORM

2 - 25 Eligible Employees

Products are underwritten by Group Health Plan, Inc. and/or
Coventry Health and Life Insurance Co.

*Incomplete information may delay the processing
of your enrollment and/or your member I.D. card.*

EMPLOYER INFORMATION: To Be Completed By Employer

Company Name:	Master Group No.:	Subgroup:	Date Employed Full Time:	Effective Date of Coverage:	Benefits Administrator Approval:	Date:	
Reason for Enrollment: <input type="checkbox"/> New Group <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Cobra <input type="checkbox"/> Hardship <input type="checkbox"/> Other: _____		Reason for Change: <input type="checkbox"/> Addition <input type="checkbox"/> Address/Phone <input type="checkbox"/> Termination, Reason & Date: _____ <input type="checkbox"/> Coverage <input type="checkbox"/> PCP Change, Reason: _____ <input type="checkbox"/> Other: _____			Employee Status: <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Retired <input type="checkbox"/> Other: _____		

EMPLOYEE INFORMATION: To Be Completed By Employee

If address and phone numbers of covered dependents are different from that of policy holder, please attach the information on a separate sheet of paper.

Last Name:	First Name:	MI:	Social Security No.:	Product Selection (Please write in plan number): <input type="checkbox"/> HMO ¹ _____ <input type="checkbox"/> POS ² _____ <input type="checkbox"/> Open Access HMO ³ _____ <input type="checkbox"/> Open Access POS ⁴ _____ <input type="checkbox"/> PPO ⁵ _____ <input type="checkbox"/> PPO Select ⁶ _____	Type of Coverage: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Spouse & Children <input type="checkbox"/> Waive (see back)	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Street Address:			Work Phone & Area Code:			
City:	State:	Zip:	Home Phone & Area Code:			

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. *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 #	SEX	DATE OF BIRTH	PRIMARY CARE NAME & I.D. NUMBER	EXISTING PATIENT	*OB-GYN NAME	HEIGHT/WEIGHT
<input type="checkbox"/> Self	<input type="checkbox"/> Add <input type="checkbox"/> Delete				- -	M F		Name I.D.#	Y N		H _____ W _____
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	<input type="checkbox"/> Add <input type="checkbox"/> Delete				- -	M F		Name I.D.#	Y N		H _____ W _____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Delete				- -	M F		Name I.D.#	Y N		H _____ W _____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Delete				- -	M F		Name I.D.#	Y N		H _____ W _____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Delete				- -	M F		Name I.D.#	Y N		H _____ W _____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	<input type="checkbox"/> Add <input type="checkbox"/> Delete				- -	M F		Name I.D.#	Y N		H _____ W _____

OTHER HEALTH INSURANCE INFORMATION: Complete or Write N/A

Name of Policy Holder:	Birthdate (mo/day/yr):	Social Security Number:
Name of Employer:		
Name of Insurance Co. or Health & Welfare Plan:	Insurance Co. Phone No.:	Effective Date:
Insurance Company Claim Address:	Insurance Policy No.:	Group No.:
List of Family Members Covered:	Name of Anyone on Medicare:	Beneficiary No.:
		Medicare A Eff. Date: Medicare B Eff. Date:

AGREEMENT: Please read the following carefully.

- I apply for membership in Group Health Plan, Inc. (GHP) for myself and for any eligible dependents listed. I authorize my employer to make deductions, if any, toward the premium cost of GHP.
- 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, & any physician, hospital, medical group or other facility providing me care, treatment or consultation, to disclose to GHP, or receive from GHP, any medical or claim information pertaining to the persons identified in this enrollment form receiving coverage under this plan, as may be necessary to enable GHP 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 conducted in accordance with state and federal confidentiality laws. GHP will not disclose any information pertaining to HIV/AIDS or chemical dependency/substance abuse except as specifically permitted by applicable law.
- I understand and agree no benefits shall take effect until this application is approved by GHP.
- 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 GHP 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 GHP

² POS (Access Plus) - HMO underwritten by GHP; Out-of-Network underwritten by Coventry Health & Life Insurance Co.

³ Open Access HMO (Sencicare) - underwritten by GHP

⁴ Open Access POS (Sencicare Plus) - Benefits underwritten by Coventry Health & Life Insurance Co.

⁵ PPO - underwritten by Coventry Health & Life Insurance Co.

⁶ PPO Select - underwritten by Coventry Health & Life Insurance Co.

HEALTH INFORMATION

Have you or any family member listed on the front of this form consulted with or been examined or treated by any health care professional during the last five (5) years for any illness, injury or health condition in any of the categories listed below? If "YES," please check the box that most appropriately describes the problem and explain fully below. I understand the purpose of the disclosure and use of my information is to allow Group Health Plan, Inc./Coventry Health and Life Insurance Co. to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. **Please note: If you leave out or misrepresent information on this form, we may terminate or not renew your coverage, or we may change your premium.**

	Yes	No	If you answered "YES," please check the appropriate box(es) below AND give more details in the space provided below.
1. Cancer/Tumor			<input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Lung <input type="checkbox"/> Melanoma <input type="checkbox"/> Other
2. Heart/Circulatory			<input type="checkbox"/> Aneurysm <input type="checkbox"/> Heart Bypass <input type="checkbox"/> Angioplasty/Stent <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Elevated Cholesterol/Triglycerides <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Blood Clots <input type="checkbox"/> Skin Ulcer <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Other
3. Reproductive			<input type="checkbox"/> Current Pregnancy (due date ___/___/____) <input type="checkbox"/> Multiples Expected (#___) <input type="checkbox"/> Pregnancy Complications (Current or Past) <input type="checkbox"/> Breast Disorders <input type="checkbox"/> Endometriosis <input type="checkbox"/> Fibroids <input type="checkbox"/> Infertility <input type="checkbox"/> Other
4. Intestinal/Endocrine			<input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Colon Disorder <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Diabetes Type 2 <input type="checkbox"/> Gallbladder <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Hiatal Hernia/Reflux <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Stomach Ulcer <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Growth Hormones <input type="checkbox"/> Other
5. Brain/Nervous			<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Other
6. Lung/Respiratory			<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other
7. Eyes/Ears/Nose/Throat			<input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Cataracts <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Deviate Septum <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy <input type="checkbox"/> Other
8. Urinary/Kidney			<input type="checkbox"/> Kidney Stones <input type="checkbox"/> Neurogenic Bladder <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Renal Failure <input type="checkbox"/> Dialysis <input type="checkbox"/> Other
9. Bones/Muscles			<input type="checkbox"/> Arthritis (Rheumatoid or Osteo) <input type="checkbox"/> Bulging/Herniated Disc <input type="checkbox"/> Joint Injury <input type="checkbox"/> Pituitary Dwarfism <input type="checkbox"/> Pulled/Strained Muscle <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Other Back/Neck Disorder <input type="checkbox"/> Other
10. Mental Health/Substance Abuse			<input type="checkbox"/> Alcoholism <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Attention Deficit Disorder <input type="checkbox"/> Bipolar/Manic Depression <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Rehab for substance abuse ___/___/____ (date of rehab) <input type="checkbox"/> Other
11. Transplant			<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Discussed Possible Future Transplant <input type="checkbox"/> Other
12. Medication			<input type="checkbox"/> Current Prescription Medications <input type="checkbox"/> Currently taking prescription medications or receiving injection or infusion therapy
13. Other			<input type="checkbox"/> Medical treatment or surgery discussed or advised, but not yet done <input type="checkbox"/> Condition or Congenital Disorder Not Mentioned Above <input type="checkbox"/> Treatment of Surgery Discussed or Advised, but not done yet
14. Tobacco Usage			<input type="checkbox"/> Anyone on this application used tobacco products in the past 12 months? Name_____ How long?_____ How many per day?_____
15. Immune			Have you or any family member listed on the front of this form been diagnosed or treated by any health care professional during the last ten (10) years for: <input type="checkbox"/> AIDS <input type="checkbox"/> HIV+ <input type="checkbox"/> Lupus <input type="checkbox"/> Other _____

IF YOU ANSWERED YES TO ANY QUESTIONS, PLEASE EXPLAIN BELOW. (If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.)

Question No.	Enrollee Name	Condition and Dates of Treatment	Medications	Is further treatment needed? If "YES," please provide an explanation of any current OR further treatment?

GENERAL PROVISIONS

1. **ENROLLMENT RIGHTS NOTICE (Waived Coverage)** - I understand that if I and/or any of my dependents, if any, waive coverage at this time and desire to participate in the plan at a future date, coverage could be subject to treatment as a late enrollee at that time. I further understand that even if I decline enrollment for myself or my dependents, spouse included, because of other health coverage at this time, I will still have the right to enroll myself and/or my dependents in this plan, provided I request enrollment within thirty-one (31) days of the time that such coverage ends. I also understand that if a new dependent relationship is formed due to marriage, birth, adoption, placement for adoption, or court order, I may be able to enroll myself and/or my dependents provided I request enrollment within thirty-one (31) days of such marriage, birth, adoption, placement for adoption or court order.

2. **RESOLUTION OF DISPUTES** - Please refer to the Certificate of Coverage, which outlines in detail GHP's Member Grievance and Appeals Procedure.

FOR HEALTH PLAN USE ONLY

Group Number:	Subscriber No.:	Date Entered/By:	Effective Date:
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