GROUP ENROLLMENT & CHANGE FORM

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:
❑ New Group ❑ New Hire ❑ Open Enrollment
❑ Cobra ❑ Hardship ❑ Other: ____

Reason for Change:
❑ Addition ❑ Address/Phone ❑ Termination, Reason & Date:
❑ Coverage ❑ PCP Change, Reason:____ ❑ Other: ____

Employee Status:
❑ Hourly ❑ Salary
❑ Retired ❑ 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.:
Street Address:			Work Phone & Area Code:
City:	State:	Zip:	Home Phone & Area Code:

Product Selection (Please write in plan number):
❑ HMO [1] ____
❑ POS [2] ____
❑ Open Access HMO [3] ____
❑ Open Access POS [4] ____
❑ PPO [5] ____
❑ PPO Select [6] ____

Type of Coverage:
❑ Employee
❑ Employee/Spouse
❑ Employee/Children
❑ Employee/Spouse & Children
❑ Waive (see back)

Marital Status:
❑ Single
❑ Married
❑ Separated
❑ Divorced
❑ Widowed

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 Sensicare 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
❑ Self	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N	
❑ Husband ❑ Wife	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N	
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N	
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N	
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N	
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N	
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete				- -	M F		Name I.D.#	Y N	

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:

[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 (Sensicare) - underwritten by GHP
[4] Open Access POS (Sensicare 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.

AGREEMENT: *Please read the following carefully.*

1. 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.
2. 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.
3. 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.
4. I understand and agree no benefits shall take effect until this application is approved by GHP.
5. 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.
6. 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: ____

GHP 7850-31 (3/06)

MO and IL Department of Insurance Approved 3/31/06

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: