



Enrollment Application

for large group eligible employees



Please PRINT to complete using black ink. Initial all corrections.
All questions must be answered.

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|---|
| Member Status Change <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Special Enrollment* <input type="checkbox"/> Benefit change <input type="checkbox"/> Additions <input type="checkbox"/> Waiving coverage <input type="checkbox"/> COBRA* If waiving coverage reason: *Complete <i>Qualifying Event</i> box below. |
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|----------------------------|-----------------------|--------------|-------------------------|
| Effective Date of Coverage | Employer / Group Name | Group Number | Benefits Admin Initials |
|----------------------------|-----------------------|--------------|-------------------------|

Employee Information

| | | | | | |
|---|-----------|------------|------|--------|--------|
| Social Security or HICN Number (required) | Last Name | First Name | M.I. | Height | Weight |
|---|-----------|------------|------|--------|--------|

| | | | | |
|---------|------|------|-------|----------|
| Address | Apt. | City | State | Zip Code |
|---------|------|------|-------|----------|

| | | | | |
|---|------|------|-------|----------|
| Mailing Address (if different than above) | Apt. | City | State | Zip code |
|---|------|------|-------|----------|

| | | | | |
|------------------------------|------------------------------|----------------|------------|---|
| Home Telephone Number () | Work Telephone Number () | E-Mail Address | Birth Date | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
|------------------------------|------------------------------|----------------|------------|---|

| | | | |
|---|--------------|---|--|
| Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other | Date of Hire | Primary Care Physician (First and Last name) Existing Patient? <input type="checkbox"/> Yes (attach proof) <input type="checkbox"/> No | Coventry/VISTA Provider ID # (located in provider directory) |
|---|--------------|---|--|

| | | |
|---|--|--|
| Qualifying Event **include legal documentation Event date: <input type="checkbox"/> Marriage** <input type="checkbox"/> Legal Guardianship** <input type="checkbox"/> Other <input type="checkbox"/> Adoption** | Dependent Child to age 30 Option Do you want to cover eligible dependents to age 30? <input type="checkbox"/> Yes <input type="checkbox"/> No | Product Selection (required) <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> PPO MHS # ____ MHS # ____ MHS # ____ |
|---|--|--|

Other Health Coverage

When coverage with Coventry/VISTA begins, will you or any dependents have any other health coverage? ___Yes ___No If "Yes", please complete the following:

Insurance Co. Name: _____ Insurance Co. Address: _____ Insurance Co. Telephone #: _____

Medicare Coverage

Do you or your covered dependents have Medicare coverage? ___Yes ___No If "Yes" please complete the following:

Name(s) _____ Medicare ID#: _____ Medicare Part A effective date: _____ Medicare Part B effective date: _____

Please select one of the following reasons for Medicare coverage: _____ Age _____ Disability _____ ESRD _____ Other

Prior Health Coverage

Have you been covered by any other health coverage within the last 12 months (or 18 months for late enrollees)? Yes No (If yes, Certificates of Creditable Coverage will be requested.)

Family Information

For dependent coverage, list each dependent below. Indicate additional dependents on a separate sheet. Except for dependents pursuing a full-time or part-time student status at an accredited institution, college, university, vocational or secondary school, dependents must maintain their primary residence in Coventry/VISTA's service area, or the dependent is not eligible for HMO coverage. If dependent is unmarried and age 25, attach proof (a) if student: a letter from registrar's office certifying current hours enrolled; or (b) if not a student but living in household: proof of legal residence (driver's license, etc); or (c) disabled: a physician's certification stating date and degree of disability. The child until the end of the calendar year in which the child turns 30, and meets the following requirements: (a) be unmarried and does not have a dependent of his/her own; (b) be a resident of Florida or a full-time or part-time student; and (c) is not provided coverage as a named subscriber, insured, enrollee, or a covered person under any other group or individual health benefit plan or is not entitled to benefits under Title XVIII of the Social Security Act.

***If a dependent who is eligible for coverage has a different last name than that of the employee, you must attach copies of supporting documentation showing evidence of his/her dependent status (birth certificate, court order for guardianship, marriage certificate, etc.).

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|---|---|-----------|------------|------|--------|--------|
| 1 | Social Security or HICN Number (required) | Last Name | First Name | M.I. | Height | Weight |
|---|---|-----------|------------|------|--------|--------|

| | | | | | |
|---|------------|--|--|--|--|
| 1 | Birth Date | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Dom Prt <input type="checkbox"/> Other | Primary Care Physician (First and Last Name) Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Coventry/VISTA Provider ID # (located in provider directory) |
|---|------------|--|--|--|--|

| | | | | | | |
|---|---|-----------|------------|------|--------|--------|
| 2 | Social Security or HICN Number (required) | Last Name | First Name | M.I. | Height | Weight |
|---|---|-----------|------------|------|--------|--------|

| | | | | | |
|---|------------|--|--|--|--|
| 2 | Birth Date | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Dom Prt <input type="checkbox"/> Other | Primary Care Physician (First and Last Name) Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Coventry/VISTA Provider ID # (located in provider directory) |
|---|------------|--|--|--|--|

| | | | | | | |
|---|---|---------------------------------------|------------|------|--------|--------|
| 3 | Social Security or HICN Number (required) | Dependent Last Name (if different***) | First Name | M.I. | Height | Weight |
|---|---|---------------------------------------|------------|------|--------|--------|

| | | | | | |
|---|------------|--|--|--|--|
| 3 | Birth Date | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Dom Prt <input type="checkbox"/> Other | Primary Care Physician (First and Last Name) Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Coventry/VISTA Provider ID # (located in provider directory) |
|---|------------|--|--|--|--|

| | | | | | | |
|---|---|---------------------------------------|------------|------|--------|--------|
| 4 | Social Security or HICN Number (required) | Dependent Last Name (if different***) | First Name | M.I. | Height | Weight |
|---|---|---------------------------------------|------------|------|--------|--------|

| | | | | | |
|---|------------|--|--|--|--|
| 4 | Birth Date | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Dom Prt <input type="checkbox"/> Other | Primary Care Physician (First and Last Name) Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | Coventry/VISTA Provider ID # (located in provider directory) |
|---|------------|--|--|--|--|

Election of Coverage and Authorization

I, on behalf of myself and all dependents, authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services provider or other medical or medically related facility or provider, insurance company (including Coventry/VISTA and affiliates), or other organization, institution or person, that has any records or knowledge of the health of me or any dependent, including but not limited to personal information, records concerning physical or mental illness, information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), the use of drugs or alcohol or other advice, diagnosis, prognosis, prescription information, care or treatment provided to me or any dependent, to release such information to Coventry/VISTA or its authorized representatives. I, on behalf of myself and all dependents, hereby provide Coventry/VISTA with consent to use personally identifiable information for general treatment, underwriting, payment or health care operations, including but not limited to coordination of care, quality assessment, utilization review, fraud detection or accreditation purposes. I understand information obtained with my authorization may be re-disclosed by Coventry/VISTA as permitted or required by law and in some instances may no longer qualify for protection under Federal and State privacy laws. I understand that my authorization is voluntary and that such information will be used by Coventry/VISTA for the purpose of evaluating my employer group's application for health insurance. If personally identifiable information is to be used for any other purpose, Coventry/VISTA will obtain specific authorization from me and all other dependents as required by applicable law. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) or such shorter period required by applicable law. Any revocation will not affect the activities of Coventry/VISTA prior to the date revocation is received by Coventry/VISTA.

I certify that all information and statements furnished by me are true and complete to the best of my knowledge. I understand that any misrepresentation or omission of any information including pre-existing conditions may result in the rescission of my or any dependent's coverage to the coverage effective date. I understand that I am financially liable for any charges incurred after the effective date until the coverage is rescinded. I hereby acknowledge Coventry/VISTA's right to require proof of any dependent's dependent status. I understand that Coventry/VISTA does not directly employ any participating providers or facilities. All health care providers and facilities are independent contractors and are not the agents or employees of Coventry/VISTA. I understand that I and all dependents must comply with the eligibility requirements as stated in the Certificate of Insurance/Certificate of Coverage, or Group Master Contract. The Certificate of Insurance/Certificate of Coverage or "Certificate" can be obtained through (i) the website at www.CHCFlorida.com for Coventry or www.vistahealthplan.com for VISTA, (ii) by contacting your Group Benefit Administrator, or (iii) by calling the Customer Service Department; for Coventry at 1-866-550-1186 and for VISTA at 1-866-VISTA-FL (1-866-847-8235) and requesting a hard copy of the Certificate be mailed via U.S. regular mail. Your signature on this application represents acceptance of these delivery options.

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree. Coventry/VISTA may rescind coverage of any member who knowingly defrauds Coventry/VISTA.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THIS APPLICATION.

X _____
Applicant Signature

Date