CoventryOne.

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	☐ M ☐ F					N/A	☐ Y ☐ N	☐ Y ☐ N
Child	☐ M ☐ F					☐ Student ☐ Disabled	☐ Y ☐ N	☐ Y ☐ N
Child	☐ M ☐ F					☐ Student ☐ Disabled	☐ Y ☐ N	☐ Y ☐ N
Child	☐ M ☐ F					☐ Student ☐ Disabled	☐ Y ☐ N	☐ Y ☐ N
Child	☐ M ☐ F					☐ Student ☐ Disabled	☐ Y ☐ N	☐ Y ☐ N
Child	☐ M ☐ F					☐ Student ☐ Disabled	☐ Y ☐ N	☐ Y ☐ 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: _____

Underwritten by Coventry Health and Life Insurance Company
Administered by Coventry Health Care of Kansas, Inc.

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

Coventry*One* Standard Plans

Kansas	Missouri
☐ **KI10C05020 25** ($500 Ded., 80%/50%)	☐ **MI10C05020 25** ($500 Ded., 80%/50%)
☐ **KI10C10025 25** ($1,000 Ded., 80%/50%)	☐ **MI10C10025 25** ($1,000 Ded., 80%/50%)
☐ **KI10C20040 30** ($2,000 Ded., 80%/50%)	☐ **MI10C20040 30** ($2,000 Ded., 80%/50%)
☐ **KI10C25045 30** ($2,500 Ded., 80%/50%)	☐ **MI10C25045 30** ($2,500 Ded., 80%/50%)
☐ **KI10C30050 35** ($3,000 Ded., 80%/50%)	☐ **MI10C30050 35** ($3,000 Ded., 80%/50%)
☐ **KI10C50065 40** ($5,000 Ded., 80%/50%)	☐ **MI10C50065 40** ($5,000 Ded., 80%/50%)
☐ **KI10C75090 50** ($7,500 Ded., 80%/50%)	☐ **MI10C75090 50** ($7,500 Ded., 80%/50%)
☐ **KI10C1000150 50** ($10,000 Ded., 80%/50%)	☐ **MI10C1000150 50** ($10,000 Ded., 80%/50%)

Coventry*One GO* Plans

Kansas	Missouri
☐ **KIGOC05020 25** ($500 Ded., 80%/50%)	☐ **MIGOC05020 25** ($500 Ded., 80%/50%)
☐ **KIGOC10025 25** ($1,000 Ded., 80%/50%)	☐ **MIGOC10025 25** ($1,000 Ded., 80%/50%)
☐ **KIGOC20040 30** ($2,000 Ded., 80%/50%)	☐ **MIGOC20040 30** ($2,000 Ded., 80%/50%)
☐ **KIGOC25045 30** ($2,500 Ded., 80%/50%)	☐ **MIGOC25045 30** ($2,500 Ded., 80%/50%)
☐ **KIGOC30050 35** ($3,000 Ded., 80%/50%)	☐ **MIGOC30050 35** ($3,000 Ded., 80%/50%)
☐ **KI10C50065 40** ($5,000 Ded., 80%/50%)	☐ **MIGOC50065 40** ($5,000 Ded., 80%/50%)
☐ **KIGOC75090 50** ($7,500 Ded., 80%/50%)	☐ **MIGOC75090 50** ($7,500 Ded., 80%/50%)
☐ **KIGOC1000150 50** ($10,000 Ded., 80%/50%)	☐ **MIGOC1000150 50** ($10,000 Ded., 80%/50%)

Qualified Plans

Kansas

☐ **KIQ10A25025 30** ($2,500 Ded., 100%/80%)

☐ **KIQ10A50050 20** ($5,000 Ded., 100%/80%)

Missouri

☐ **MIQ10A25025 30** ($2,500 Ded., 100%/80%)

☐ **MIQ10A50050 20** ($5,000 Ded., 100%/80%)

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: _____

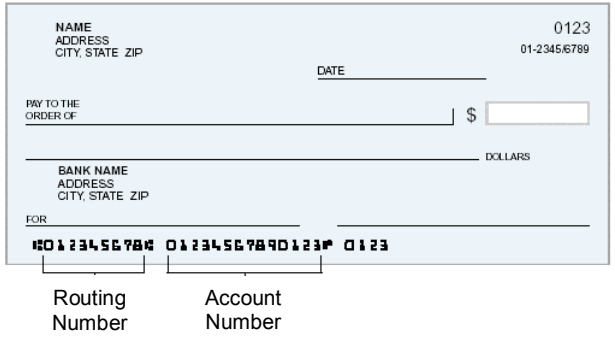
Routing Number _____ Account Number _____

Address of Bank _____

Name that appears on the Account _____

Address on the Account _____

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



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: _____

Underwritten by Coventry Health and Life Insurance Company
Administered by Coventry Health Care of Kansas, Inc.

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.

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: _____

Underwritten by Coventry Health and Life Insurance Company
Administered by Coventry Health Care of Kansas, Inc.

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 #

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 #

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 #

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 #

Applicant Last Name: ______________________________ First Name: ______________________________

Underwritten by Coventry Health and Life Insurance Company
Administered by Coventry Health Care of Kansas, Inc.

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 _____ Signature of General Agent _____

Phone Number _____ Email Address _____

Office Use Only

Applicant Last Name: _____ First Name: _____