Application / Health Statement Form

FOR INTERNAL USE ONLY
EL CODE_________
☐ ACH ☐ NON-ACH
☐ HSA OPT-OUT ☐ PDP

Submit completed Application / Health Statement Form to: Coventry Health Care of Iowa, Inc. 4320 114th Street Urbandale, IA 50322/fax: 866-533-1960

To ensure timely processing of this Application:

√ Use only blue or black ink
√ All questions must be answered completely and accurately
√ The Application must be signed and dated in each required section by all required Applicants
√ All corrections must be initialed and dated; correction fluid is not permitted
√ This Application is valid sixty (60) days from the earliest date of signature in the Conditions of Enrollment section.

FOR BROKER USE ONLY
Amount quoted for requested effective date:
$___________ / Month
☐ Individual ☐ Family
Payroll Deduction Program (PDP)
☐ Not Applicable
Name of PDP ___________________________________

Check all that apply:

☐ New Application ☐ Plan Benefits Increase ☐ Plan Benefits Decrease ☐ Dependent Add
☐ Reinstatement ☐ New Minor Child-Only Application (under 18 years old)

REQUESTED EFFECTIVE DATE
☐ 1st day of __________20_____

APPLICANT AND DEPENDENT INFORMATION

PRIMARY APPLICANT If Minor Child-Only Application, complete information about the child(ren)'s parent or legal guardian in this section.

Last name	First name			MI	Home phone ( ) -
Residence address	City	State	ZIP code	County	
E-mail address				Business phone ( ) -	
Best time and place to receive a call from Coventry Health Care of Iowa, Inc. regarding this Application, if necessary: ☐ Home ☐ Business ☐ Other (____)________________ ☐ Morning ☐ Afternoon ☐ Evening				Relationship (if Minor Child-Only Application)	
Mailing address (If different from address above)	City	State	ZIP code		

PRIMARY APPLICANT'S SPOUSE (If applying for coverage in this Application)

Last name	First name			MI	Home phone ( ) -
Residence address	City	State	ZIP code	County	
E-mail address				Business phone ( ) -	
Best time and place to receive a call from Coventry Health Care of Iowa, Inc. regarding this Application, if necessary: ☐ Home ☐ Business ☐ Other (____)________________ ☐ Morning ☐ Afternoon ☐ Evening					
Mailing address (If different from address above)	City	State	ZIP code		

Applicant Name:_________________________________ **Broker:**____

PRIMARY APPLICANT AND ALL DEPENDENTS APPLYING FOR COVERAGE

1. Are all persons applying for coverage in this Application legal residents of the United States? ☐ Yes ☐ No
2. Have all persons applying for coverage in this Application legally resided in the United States for the past six (6) consecutive months? ☐ Yes ☐ No

   If no, indicate person(s): ______

   Country of residency:______ Date of entry into the United States (mm/yyyy) ______
3. To be eligible for coverage, care must be established with a physician located in the United States as of the date of this Application. Has care been established with a physician located in the United States for all persons applying for coverage in this Application? ☐ Yes ☐ No

   If no, indicate person(s): ______
4. List Primary Applicant and all Dependents applying for coverage in this Application:

Full Name (Last, First, MI)	Gender (circle one)	Relationship to the Primary Applicant	Age	Birthdate (mm/dd/yyyy)	Disabled dependent?[1]	Social Security Number	Height (ft. in.)	Weight (lbs)	Tobacco use?[2]
1.	M / F	SELF			N/A				☐ Yes ☐ No
2.	M / F	SPOUSE			N/A				☐ Yes ☐ No
3.	M / F				☐ Yes ☐ No				☐ Yes ☐ No
4.	M / F				☐ Yes ☐ No				☐ Yes ☐ No
5.	M / F				☐ Yes ☐ No				☐ Yes ☐ No
6.	M / F				☐ Yes ☐ No				☐ Yes ☐ No
7.	M / F				☐ Yes ☐ No				☐ Yes ☐ No

[1] Please check the appropriate box if the listed dependent is disabled.
[2] 'Tobacco use' constitutes use of tobacco or tobacco cessation products in the past twelve (12) months. If yes, provide details in the Additional Information Section

5. Are all of the Primary Applicant's dependent children accounted for in this Application for coverage? ☐ Yes ☐ No

   If no, explain: ______
6. Is anyone applying for coverage in this Application required to provide health care coverage for a child pursuant to a qualified medical child support order or other court order? ☐ Yes ☐ No

   If yes, explain:______
7. Do all dependent children included in this Application reside with the Primary Applicant? ☐ Yes ☐ No

   If no, complete the Custodial Parent section below. Note that the Custodial Parent must also sign the Authorization of Release of Information and Conditions of Enrollment section of this Application.

Child Name (Last, First, MI)	Custodial Parent Name (Last, First, MI)	Custodial Parent Address	Relationship to child
1.			
2.			
3.			

Applicant Name:______ **Broker:**______

PLAN SELECTION

Indicate one (1) plan selection below for which all Applicants are applying.

Spectrum*
- ☐ 20/1500/90
- ☐ 20/2500/90
- ☐ 20/3500/90
- ☐ 20/5000/90

Torch
- ☐ 30/1000/80
- ☐ 30/1500/80
- ☐ 30/2500/80
- ☐ 30/3500/80
- ☐ 30/5000/80
- ☐ 30/7500/80
- ☐ 30/10000/80

Prism QHH
- ☐ 2000/100
- ☐ 2500/100
- ☐ 3500/100
- ☐ 5000/100

HealthGear
- ☐ A2500
- ☐ A5000
- ☐ B3500
- ☐ B5000
- ☐ C3500
- ☐ C5000

*Maternity benefits for this plan begin twelve (12) months from the original effective date of the policy.
If plan selection equals QHH, proceed to the Health Savings Account (HSA) Selection section

HEALTH SAVINGS ACCOUNT (HSA) SELECTION

This section is only applicable when the plan selected in the Plan Selection section is a Qualified High Deductible Health Plan (QHH). If Plan Selection is not a QHH, skip to the Other Health Insurance Information section.

Your Health Savings Account (HSA) is your financial asset even if you change health plans or are no longer covered by Coventry*One*. To open an HSA, you must meet three (3) criteria:

1. You must be covered by a Qualified High Deductible Health Plan (QHH);
2. You cannot be covered by another health plan, including Medicare; and
3. You cannot be claimed as a Dependent on another individual's tax return.

If you have selected a Coventry*One* Qualified High Deductible Health Plan (QHH) and are otherwise eligible, you will receive a Health Savings Account (HSA) through our HSA trustee, HealthEquity, at no additional charge. You will be able to contribute to this tax-advantaged account to help you put aside money to fund your medical claims before meeting your deductible and save for future medical expenses. As an additional benefit, HealthEquity will provide 24/7 telephonic support and online information to help you better manage this account.

If you have selected a Coventry*One* QHH product and DO NOT want to take advantage of the HSA account, please check the "OPT-OUT" box below. Otherwise, you will receive a welcome kit and HSA debit card from HealthEquity, subject to this Coventry*One* QHH Application approval and acceptance.

☐ **OPT-OUT of having an HSA opened through HealthEquity**

OTHER HEALTH INSURANCE INFORMATION

1. Is anyone applying for coverage in this Application covered by or eligible for coverage under Medicare? ☐ Yes ☐ No

   If yes, list the Applicants who are covered by or eligible for coverage under Medicare as of the requested effective date.
   If so, this person(s) is not eligible for coverage ____________________

2. Has anyone applying for coverage in this Application ever:

   A) Applied for Coventry Health Care of Iowa, Inc. or any other Coventry Health Care plan? ☐ Yes ☐ No

   List the Applicants who have previously applied:____________________

   B) Previously been enrolled in Coventry Health Care of Iowa, Inc. or any other Coventry Health Care plan? ☐ Yes ☐ No

   List the Applicants who have been previously enrolled: ____________________

   C) Currently enrolled in Coventry Health Care of Iowa, Inc. or any other Coventry Health Care plan? ☐ Yes ☐ No

   List the Applicants currently enrolled: ____________________

3. In the **PAST FIVE (5) YEARS**, has anyone applying for coverage in this Application had any form of life or health insurance denied, cancelled, postponed, had a waiver applied or been charged extra premium for life, disability or health insurance, or had such insurance rescinded or involuntarily terminated, restricted or rated up? ☐ Yes ☐ No

   If yes, complete information below:

Applicant Name (Last, First, MI)	Type of insurance (circle)	Name of company	Reason
1.	Health / Life / Disability		
2.	Health / Life / Disability		
3.	Health / Life / Disability		

Applicant Name:____________________ **Broker:**____________________

4. Is any person applying for coverage in this Application covered by any other health insurance? ☐ Yes ☐ No

If no, skip to Creditable Coverage section. If yes, continue below:

Applicant Name (Last, First, MI)	Name of Company	Type of coverage (Group, Individual, COBRA, Short-Term, etc.)	Replacing other coverage?** (Circle one)	If yes, anticipated Policy Term Date (mm/dd/yyyy)
1.			☐ Yes ☐ No	
2.			☐ Yes ☐ No	
3.			☐ Yes ☐ No	

** Is the coverage being applied for in this Application intended to replace other carrier's coverage?
If 'yes,' please review and sign the following **NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE** as required by Iowa law**:**

According to the information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Coventry Health Care of Iowa, Inc. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

a) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
b) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
c) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

I REVIEWED THE ABOVE "NOTICE TO APPLICANT" ON:

DATE:________________________ **APPLICANT'S SIGNATURE:**__________________________________

DO NOT cancel existing insurance coverage until notified in writing of approval of this Application by Coventry*One* .

CREDITABLE COVERAGE AND PRE-EXISTING LIMITATION CREDIT

CREDITABLE COVERAGE

Under Iowa law, if anyone applying for coverage in this Application is an "eligible individual," that eligible individual(s) may be entitled to waiver of any pre-existing medical condition exclusions in their policy. To be an eligible individual, the following requirements must be met:

Applicant name:____

1. Individual has had coverage for at least twelve (12) continuous months without a break in coverage of 63 days or more; ☐ Yes ☐ No
2. Individual's most recent coverage was under a health plan which can be demonstrated by a certificate of creditable coverage; ☐ Yes ☐ No
3. Individual's prior coverage was not involuntarily terminated because of fraud or nonpayment of premiums; ☐ Yes ☐ No
4. Individual is not eligible for COBRA continuation coverage or has exhausted COBRA benefits (or continuation coverage under a similar state provision); ☐ Yes ☐ No
5. Individual is not eligible for a group health plan or Medicare and does not have any other health insurance coverage. ☐ Yes ☐ No

Failure to answer the questions in this section accurately may result in the loss of rights as an eligible individual including the waiver of the pre-existing condition exclusion**. It is each individual's responsibility to provide the Certificate(s) of Creditable Coverage covering the prior twelve (12) continuous months in order to establish eligibility. All Certificate(s) of Creditable Coverage must be presented at the time of the Application. If unavailable at the time of Application, the Certificate(s) of Creditable Coverage should be faxed to the Coventry*One* Enrollment Department at 866-533-1960 immediately upon its receipt from issuing entity.**

APPLYING CREDITABLE COVERAGE TO PRE-EXISTING CONDITION EXCLUSION PERIOD

If you have proof of prior creditable coverage without a break in coverage of 63 days or more and would like to use it to credit any required pre-existing condition limitation, you must include a copy of that creditable coverage document at the time of Application. Using your creditable coverage credit may result in an adjustment to your quoted rate. ☐ Yes, attachment included.

LIFESTYLE AND HEALTH HISTORY

Check 'Yes' or 'No,' when applicable. **Answer all questions completely**. Unanswered questions will delay or stop processing. Provide details in the Additional Information section. In order to process your Application, additional information may be required. If in doubt, it may be helpful to complete this application with the help of your physician. A Coventry*One* representative may call you to discuss your Application. You may be asked to complete a questionnaire or to provide medical records. It is the Applicants' responsibility to obtain medical records. Costs incurred to obtain medical records to process this Application are the responsibility of the Applicant. Failure to obtain the needed information will result in our inability to process the Application.

If the health status of any Applicant herein changes between the signature date of this Application and the latter of the coverage effective date or approval date, Coventry Health Care of Iowa, Inc. must be notified of the change in writing.

LIFESTYLE QUESTIONS

	Question	Answer
1.	Is anyone listed in this Application (whether applying for coverage or not) currently pregnant, an expectant or surrogate parent, or in the process of adopting a child?	☐ Yes ☐ No
2.	Has any person applying to be covered **EVER**:	
	A) Been advised to seek treatment for alcohol use or been advised to reduce alcohol intake, or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism?	☐ Yes ☐ No
	B) Been a member of any alcohol or drug support group?	☐ Yes ☐ No
	C) Used any illegal drugs or substances, or controlled substance not prescribed by a doctor, or been counseled for, diagnosed with, or treated for drug or chemical use or dependents (including prescription, non-prescription, or illegal)?	☐ Yes ☐ No
3.	In the past **FIVE (5) YEARS**, has anyone applying for coverage in this Application been cited or convicted of driving under the influence of alcohol or any drug?	☐ Yes ☐ No
4.	Within the past **12 months**, has any person to be covered consumed alcoholic beverages? (*Note: Even if only on occasion, please provide the number of drinks consumed on such occasions.*) Applicant Name __________________ Number of drinks consumed per week: ☐ 0-7 ☐ 8-14 ☐ 15-20 ☐ 21-26 ☐ 27-35 ☐ 36 or more Applicant Name __________________ Number of drinks consumed per week: ☐ 0-7 ☐ 8-14 ☐ 15-20 ☐ 21-26 ☐ 27-35 ☐ 36 or more Applicant Name __________________ Number of drinks consumed per week: ☐ 0-7 ☐ 8-14 ☐ 15-20 ☐ 21-26 ☐ 27-35 ☐ 36 or more	☐ Yes ☐ No
5.	Has anyone applying for coverage in this Application **EVER** been convicted of a felony, or been on, or is currently on probation? If yes, identify the person and details in the Additional Information Section.	☐ Yes ☐ No

HEALTH QUESTIONS

	Question	Answer
6.	Has anyone applying for coverage in this Application **EVER** been treated for cancer, including but not limited to: melanoma, Hodgkin's disease, malignant sarcomas, carcinomas, tumors or cysts; or heart attack, heart disease, stroke, aneurysm, multiple sclerosis, or hepatitis C? If cancer, provide location, type, stage, and treatment in the Additional Information Section.	☐ Yes ☐ No
7.	Does anyone applying for coverage in this Application **HAVE OR EVER** had any implants (breast or penile), devices such as pacemakers, shunts, stents, valve replacements, monitoring devices or internal fixation devices (plates, pins or screws) or prosthetics?	☐ Yes ☐ No
8.	Within the past **TEN (10) YEARS**, has anyone applying for coverage in this Application had any signs or experienced symptoms that caused them or would cause an ordinary prudent person to seek advice, treatment or therapy, or consulted or sought medical treatment, been diagnosed, had medical treatment recommended, received medical treatment or therapy, been surgically treated, or been hospitalized for any of the following conditions:	
	A) Cardiovascular disorders, **including but not limited to**: hypertension, or high blood pressure, chest pain, heart murmur, mitral valve prolapse, palpitations or heart rhythm disturbance or surgery? If history of hypertension, high blood pressure or elevated blood pressure readings, provide three (3) blood pressure readings and dates, including the highest reading within the last **SIX (6) MONTHS.** These readings must have been taken by a physician. Date ________ Reading _______ Date ________ Reading _______ Date ________ Reading ______ Highest reading in last SIX (6) MONTHS: Date ________ Reading _________	☐ Yes ☐ No

Applicant Name:_________________________________ **Broker:**____

	B) Blood disorders, **including but not limited to**: anemia, hemophilia, purpura, thrombocytopenia, leukemia, abnormal white or red blood cells or abnormal bleeding?	☐ Yes ☐ No
	C) Vein or artery disorders, **including but not limited to**: phlebitis, thrombosis, varicose veins or ulcers, peripheral vascular disease or clots and poor circulation?	☐ Yes ☐ No
	D) Connective tissue disorders, **including but not limited to**: systemic (SLE) or discoid lupus, scleroderma, rheumatoid arthritis, CREST or Sjogren's syndromes?	☐ Yes ☐ No
	E) Cerebrovascular disorders, **including but not limited to**: stroke, transient ischemic attack (TIA), carotid bruits, or cerebral (brain) hemorrhage?	☐ Yes ☐ No
	F) Immune or lymph system disorders, **including but not limited to**: persistent lymph node enlargement, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV), persistent fever, persistent diarrhea, persistent fatigue, or weight loss of unknown cause?	☐ Yes ☐ No
	G) Nervous system disorders, **including but not limited to**: migraines, dizziness, epilepsy, fainting, tremors, convulsions, seizures, paralysis, autism, Alzheimer's, Parkinson's, amyotrophic lateral sclerosis (ALS) or cerebral palsy?	☐ Yes ☐ No
	H) Respiratory system disorders, **including but not limited to**: asthma, sinusitis, allergic rhinitis, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), dyspnea, tuberculosis, sarcoidosis or sleep apnea?	☐ Yes ☐ No
	I) Metabolic or endocrine disorders, **including but not limited to**: obesity, elevated lipids (cholesterol, triglycerides), diabetes; disorder of the thyroid, pituitary, adrenal, pancreas or other gland or goiter?	☐ Yes ☐ No
	J) Musculoskeletal disorders, **including but not limited to**: arthritis, fibromyalgia, gout, back, neck or spinal column disorders such as herniated disc(s); osteopenia/osteoporosis, ankylosing spondylitis, fractures, dislocations or disorders, polio/post-polio syndrome, muscular dystrophy, amputation, or persistent or recurring pain of the muscles, bones or joints or had spinal adjustments or manipulation therapy?	☐ Yes ☐ No
	K) Urinary tract disorders, **including but not limited to**: kidney or bladder stones, cystitis or other urinary tract infections, urethral stricture or stenosis, kidney transplant or dialysis, renal failure or polycystic kidney disease?	☐ Yes ☐ No
	L) Hernias, **including but not limited to**: inguinal, scrotal, hiatal (diaphragmatic) or umbilical?	☐ Yes ☐ No
	M) Female reproductive system disorders, **including but not limited to**: infertility, irregular menstruation, uterine fibroids, uterine prolapse, endometriosis, abnormal PAP smears, caesarian section or other complications of pregnancy? Date / results of most recent PAP smear: Date (mm/yyyy): __________ Results: ________________ Date / results of first prior PAP smear: Date (mm/yyyy): __________ Results: ________________	☐ Yes ☐ No
	N) Ear, eye, nose, throat or skin disorders, **including but not limited to:** recurrent ear infections, Meniere's disease, deafness, blindness, cataracts, detached retina, glaucoma, optic atrophy, deviated nasal septum, nasal polyps, psoriasis, acne or skin tumors?	☐ Yes ☐ No
	O) Breast disorders, **including but not limited to:** breast cysts or tumors, fibrocystic breast disease, gynecomastia, mastitis or abnormal mammograms?	☐ Yes ☐ No
	P) Male reproductive disorders, **including but not limited to:** prostate disorder(s), elevated PSA testing, erectile dysfunction, infertility or male genital disorder?	☐ Yes ☐ No
	Q) Mental or nervous disorders, **including but not limited to:** attention deficit disorder, anxiety, depression, eating disorders, bipolar disorder, schizophrenia or psychotic disorder?	☐ Yes ☐ No
	R) Intestinal or rectal disorders, **including but not limited to**: Crohn's disease, ulcerative colitis, intestinal polyps, hemorrhoids, irritable bowel syndrome (IBS), diverticulitis / diverticulosis?	☐ Yes ☐ No
	S) Sexually transmitted diseases, **including but not limited to**: gonorrhea, chlamydia, human papillomavirus (HPV), syphilis, genital warts or genital herpes?	☐ Yes ☐ No
	T) Digestive system disorders, **including but not limited to**: gastroesophageal reflux disease (GERD), esophageal stricture, esophageal varices, cirrhosis or other liver disorder, spleen disorder, stomach or duodenal ulcer(s), gallbladder disease or gall stones?	☐ Yes ☐ No
	U) Abnormal diagnostic tests, **including but not limited to:** abnormal blood tests, abnormal MRI or CT scan, x-ray, bone density, abnormal electrocardiogram (EKG) or echocardiogram?	☐ Yes ☐ No
9.	Within the past **FIVE (5) YEARS**, has any person applying for coverage in this Application:	
	A) Consulted or been examined or treated by any physician, chiropractor, psychologist, or other health care practitioner?	☐ Yes ☐ No
	B) Been to a clinic, hospital, emergency room, or other medical facility for treatment, confinement, or observation?	☐ Yes ☐ No
	C) Had or been advised to have a surgical procedure, tests or treatment that have not yet been performed?	☐ Yes ☐ No
	D) Had any disease, disorder, ailment, injury or condition not listed in this Application for which there have been, or are plans or intentions to seek advice, diagnosis, or treatment?	☐ Yes ☐ No

Applicant Name:_________________________________ **Broker:**____

PRESCRIPTION MEDICATIONS AND INJECTION THERAPY

List all medications and injection therapy taken or prescribed within the last **TWELVE (12) MONTHS** for any Applicant listed on this Application. Please include any over-the-counter (OTC) medications taken on a regular basis. If additional space is needed, list on a separate sheet of paper and attach to this Application to include the signature and date signed by the Applicants.

Applicant Name (Last, First, MI)	Medication / Dosage / Frequency (e.g., Lopressor™ / 100mg / daily)	Reason Prescribed / Taken	Date Prescribed (mm/dd/yyyy)	Still taking?	Date discontinued (mm/dd/yyyy)	Name, Address and Phone Number of Prescribing Physician
				☐ Yes ☐ No		
				☐ Yes ☐ No		
				☐ Yes ☐ No		
				☐ Yes ☐ No		
				☐ Yes ☐ No		

ADDITIONAL INFORMATION

If any **lifestyle** or **health history** questions were answered with 'yes,' the following information must be completed. Please explain and provide **FULL DETAILS** for each 'yes' answer to any condition(s) checked in the preceding questions and **INDICATE TO WHICH APPLICANT THE INFORMATION APPLIES.** If additional space is needed, list on a separate sheet of paper and attach to this Application to include the signature and date signed by the Applicants.

Q #	Applicant Name (Last, First, MI)	Conditions, treatment, operations (Indicate number of occurrences)	Date of onset (mm/yyyy)	Date of recovery (mm/yyyy)	Days in hospital	Last checkup for condition (mm/yyyy)	Results	Name, Address and Phone Number of Health Care Provider

Applicant Name:________________________________ **Broker:**____

NAMES OF HEALTH CARE PROVIDERS NOT LISTED ABOVE

Applicant Name (Last, First, MI)	Name, Address and Phone Number of Health Care Provider	Details of Last Visit		
		Date (MM/YYYY)	Reason for Visit	Result (Circle one. If abnormal, explain)
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal

Applicant Name:_________________________________ **Broker:**____

CONDITIONS OF ENROLLMENT

I represent that all information on this Application form is complete and accurate and true to the best of my knowledge. I understand that my answers to the questions on this form will be used as the basis to determine eligibility for coverage. I further understand that if any information is omitted or intentionally misrepresented, it could provide the basis to refuse, reform or rescind coverage and to adjust premiums as applicable, or 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. I understand that if my health or any of the answers or statements provided herein change prior to notification of an offer of coverage, I must inform Coventry*One* of such in writing. I understand that failure to do so may result in the denial, reformation or rescission of coverage.

I understand and acknowledge that the selling agent, if applicable to this Application for coverage, has no authority to promise coverage to Applicants herein or to modify Coventry*One* underwriting policy or the terms of Coventry Health Care of Iowa, Inc. coverage.

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.

THE EFFECTIVE DATE OF COVERAGE OF APPLICANTS LISTED HEREIN IS ASSIGNED BY COVENTRY*ONE* AT ITS DISCRETION, SUBJECT TO MEDICAL UNDERWRITING; AND AN OFFER OF COVERAGE AND PREMIUM AMOUNT BEING PRESENTED AND ACCEPTED.

DO NOT CANCEL EXISTING INSURANCE COVERAGE UNTIL NOTIFIED IN WRITING BY COVENTRY HEALTH CARE OF IOWA, INC. OF APPLICATION APPROVAL.

PRIMARY APPLICANT'S SIGNATURE	DATE	**SPOUSE'S SIGNATURE** (If applying for coverage	DATE
DEPENDENT APPLICANT SIGNATURE*	DATE	**DEPENDENT APPLICANT SIGNATURE***	DATE

*Required age 18 and over.

If minor child-only application (under the age of 18), this section must be signed by the minor child (children's) parent or legal guardian identified in the Applicant and Dependent Information Section. ☐ **Check here if N/A**

PARENT / LEGAL GUARDIAN SIGNATURE	**PRINT NAME**	**RELATIONSHIP TO APPLICANT**	**DATE**

Applicant Name:________________________________ **Broker:**____

PREMIUM PAYMENT

Premiums due for coverage under a policy pursuant to the approval of this Application and acceptance of coverage will be paid from funds automatically deducted from either a checking or savings account, upon the Account Holder's authorization herein, subject to the Coventry Health Care of Iowa, Inc. approval of this Application and the acceptance of an offer of coverage. To facilitate the premium withdrawal this section must be completed in its entirety. This payment information does not guarantee approval or coverage.

Please Provide: ☐ Checking Account ☐ Savings Account

Name of Bank or Savings Institution: ________________________________

9-Digit Routing Number: |___|___|___|___|___|___|___|___|___|

Account Number: ____ _____
(A voided check or savings account deposit slip should be attached in support of content in this section)

NAME
ADDRESS
CITY, STATE ZIP
0123
01-2345/6789
DATE
PAY TO THE ORDER OF $
DOLLARS
BANK NAME
ADDRESS
CITY, STATE ZIP
FOR
⑆012345678⑆ 0123456789012⑈ 0123
ROUTING # ACCOUNT #

Name of Account Holder: ____

Relationship of Account Holder to the Primary Applicant: ☐ Self ☐ Spouse ☐ Other ____________________

Permanent Address of Account Holder: ____

____

Applicable premium amount is automatically withdrawn from the account provided herein on the 10th day of each current coverage month, or next business day. The initial premium withdrawal may not occur until the 10th of the month following the first month of coverage and will account for the total amount owed from the original effective date. For example, if the first months' premium is calculated beginning on the 15th of the month but not withdrawn until the 2nd month of coverage, the amount due in the 2nd month will equal one and one half (1½) the total monthly premium amount. If the first months' premium is calculated beginning on the 1st of the month but not withdrawn until the 2nd month of coverage, the amount due in the 2nd month will be twice the total monthly premium amount.

If premium payment is returned unpaid a Return Check Fee amount will be assessed in the amount of $20.00. Account Holder hereby authorizes Coventry Health Care of Iowa, Inc. to collect the premium payment due on the 20th of the month, or next business day, including the Return Check Fee amount, via electronic funds transfer (EFT) or automatic withdrawal from the account identified and provided herein or then current.

By signing below, I authorize Coventry Health Care of Iowa, Inc. to initiate automatic withdrawal of applicable premium payments from the account listed above.

I, the Account Holder, acknowledge and understand that it is my responsibility to notify Coventry Health Care of Iowa, Inc. at 1-866-364-5663 should the payment information provided herein change while a policy of coverage pursuant to this Application remains in force and effect.

Account Holder Signature:____ **Date:**__________________________

Applicant Name:_________________________________ **Broker:**____

PRODUCER INFORMATION

The following sections are to be completed by the producer.

Broker Name:	Broker ID #:	Broker Email Address:
Broker Signature:	Agency Name:	Broker/Agency Phone: ( )
Name of General Agent:	Payee (who is paid the commissions) ☐ Broker ☐ Agency ☐ General Agent	Payee Tax ID#

PRODUCER CERTIFICATION

I am not aware of any other information which may have a bearing on the insurability of anyone to be covered and have not altered any responses recorded on this Application or any supplement to it. I have not advised the Applicant to withhold any information regarding the answers to the questions and have advised the Applicant to review the Application and the answers recorded to confirm completeness and accuracy. I further attest that all my answers recorded above are correct, complete, and wholly true to the best of my knowledge and belief.

Producer Signature ____ **Date**___________________________

Applicant Name:__________________________________ **Broker:**____

AUTHORIZATION OF RELEASE OF INFORMATION

I, for myself and any of my Dependents who are under the age of 18 who and are applying for coverage hereunder, hereby make the following authorizations:

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, insurance company, claims administrator, employer, governmental agency or other person or firm, to disclose to Coventry Health Care of Iowa, Inc. or its authorized representatives, my (or my Dependents') personal information, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to me, including without limitation, information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or the use of drugs or alcohol. I also authorize the release of information relating to mental illness.

In addition, I authorize Coventry Health Care of Iowa, Inc. to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by Coventry Health Care of Iowa, Inc. for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for Coventry Health Care of Iowa, Inc. to consider my Application and to determine whether or not an offer of coverage will be made. No action will be taken on my Application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by Coventry Health Care of Iowa, Inc. as permitted or required by law and may no longer be protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request.

I authorize Coventry Health Care of Iowa, Inc. to use or disclose the information I provide in this Application (or that Coventry Health Care of Iowa, Inc. has or receives from third parties) for purposes of administering my health insurance benefits. 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 law. Any revocation will not affect the activities of Coventry Health Care of Iowa, Inc. prior to the date such revocation is received by Coventry Health Care of Iowa, Inc.

PRIMARY APPLICANT'S SIGNATURE	DATE	**SPOUSE'S SIGNATURE** (If applying for coverage)	DATE
DEPENDENT APPLICANT SIGNATURE*	DATE	**DEPENDENT APPLICANT SIGNATURE***	DATE

*Required age 18 and over.

If minor child-only application (under the age of 18), this section must be signed by the minor child (children's) parent or legal guardian identified in the Applicant and Dependent Information Section. ☐ **Check here if N/A**

PARENT / LEGAL GUARDIAN SIGNATURE	**PRINT NAME**	**RELATIONSHIP TO APPLICANT**	**DATE**

Applicant Name:________________________________ **Broker:**____