HealthAmericaOne.

Pennsylvania 2016
Application for HealthAmerica Individual Health Insurance

Aetna Health Inc. dba HealthAmerica Pennsylvania, Inc.

Primary Applicant's Name

Applicant's Social Security Number

INSTRUCTIONS:

- **Complete in blue or black ink only.**
- **PRINT clearly.**
- **All answers must be complete and truthful.**

IMPORTANT NOTES:

- **The information you provide is confidential.**
- **Intentional misrepresentation may result in the policy being modified or terminated.**
- **Proof of state residency may be required.**
- **YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.**

Section A – Primary Applicant Information (for parent/guardian for Child-Only application)

Primary Applicant Last Name	First Name	Middle Initial
Home Address (No PO Boxes)		Apt. Number

City	State	ZIP Code	County

Relationship (If Child-Only Application)

Mailing Address (If different from your Home address)		
City	State	ZIP Code

E-mail Address

Telephone Number	If we need to call you with questions about your application, when is the best time to reach you?
Home (____) _____ **Work** (____) _____ **Mobile** (____) _____	☐ Morning ☐ Afternoon ☐ Evening

Section B – Application Type

Application Type (Select one):

☐ New medical coverage ☐ Child-Only Application (Children up to age 21)

☐ Change current coverage ☐ Add dependent(s) to current coverage

Your Effective Date will be assigned by HealthAmerica, based on the receipt date of your application.

Primary Applicant's Name

Section C – Enrollment Period

☐ **Annual Open Enrollment Period** (Annual period to enroll in medical coverage if no Special Enrollment Period applies. If you qualify for a Special Enrollment Period during the Annual Open Enrollment Period, coverage may start sooner.)

☐ **Special Enrollment Period** (If you qualify for a Special Enrollment Period, you can enroll in medical coverage outside the Annual Open Enrollment Period. If you qualify for a Special Enrollment Period during the Annual Open Enrollment Period, coverage may start sooner.)

If one of the events listed below applies to you, check the appropriate box.

The Special Open Enrollment Period for the following events begins 60 days prior to the date of the event checked and continues for 60 days after.

Date of Event	Event
_____	☐ Loss of employer coverage due to termination of employment, reduction in hours, coverage no longer offered to my employment class, or expiration of COBRA coverage.
_____	☐ Loss of employer or individual coverage because no longer eligible as a dependent.
_____	☐ Loss of employer or individual coverage because of divorce from policyholder, death of policyholder, or policyholder enrolled in Medicare.
_____	☐ Loss of Medicaid or CHIP coverage.
_____	☐ Coverage needed following loss of eligibility for Exchange subsidies.
_____	☐ A permanent move.

The Special Open Enrollment Period for the following events begins on the date of the event checked and continues for 60 days.

_____	☐ Coverage needed for new dependent through marriage.
_____	☐ Coverage needed for new dependent through birth, adoption or placement for adoption.
_____	☐ Other, please explain. _____

Section D – Coverage Selection

Choose the plan that best meets your needs.

Bronze:	**Silver:**	**Gold:**
☐ Coventry Bronze $15 Copay OAHMO PD	☐ Coventry Silver $10 Copay OAHMO PD	☐ Coventry Gold $10 Copay OAHMO PD
☐ Coventry Bronze Deductible Only HSA Eligible OAHMO PD		

Health Savings Account (HSA) If you have selected an HSA Eligible plan, you are eligible to open a Health Savings Account (HSA) through our HSA trustee, HealthEquity. After enrollment, you will receive information from HealthEquity with instructions to set up your HSA account.

Primary Applicant's Name

Section E – Persons Requesting Coverage

List all family members you wish to be covered under this policy.

Dependent children are eligible up to age 26.

For a Child-Only application, start listing children at Child 1, with the youngest child listed first.

☐ Check here if you need more space to provide information for additional dependents. Use a separate sheet of paper and staple to the back of this application.

If any person has regularly used tobacco products (cigarettes, pipe, cigars, snuff, or chewing tobacco) within the last six (6) months, check "Yes" as Tobacco User below (This does not apply to applicants under the age of 18). Regular use means an average of four or more times per week.

If any person uses tobacco for religious or ceremonial purposes only, check "No" for Tobacco User below.

A list of participating providers can be found at www.coventryone.com by selecting the Find a Doctor link.

Primary Applicant Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Spouse/Domestic Partner Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 1 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 2 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 3 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 4 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 5 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No

continued

Primary Applicant's Name

Section E – Persons Requesting Coverage (Continued)

To be completed by the Primary Applicant

Marital Status ☐ Married ☐ Domestic Partner ☐ Single	Are you a resident of the state in which you are applying? ☐ Yes ☐ No
If you are currently covered by accident and sickness insurance, is this plan intended to replace your current coverage? ☐ Yes ☐ No	
How would you like HealthAmerica to communicate with you regarding your application and coverage? ☐ E-mail ☐ Mail	Would you like to receive e-mails from us regarding your benefits, programs and general health information? ☐ Yes ☐ No
Would you like to turn off paper? ☐ Yes ☐ No If you turn off paper, we will send you e-mails about your claims and other activity on your account. You can also view your statements and communications online. Please note that there may be state or federal regulations that prohibit us from communicating with you in your preferred method.	
Are any applicants enrolled in or entitled to Medicare benefits? ☐ Yes ☐ No If Yes, provide name(s) of these applicants: _____	
Are all applicants listed on this application Citizens of the United States? ☐ Yes ☐ No If "No," provide Name and most recent date of arrival in the U.S. **Proof of state residency will be required.** Name _____ Most recent arrival date _____ _____ _____ _____ _____	
Do you read and write English? ☐ Yes ☐ No (If "No", you must complete the Statement of Accountability.) If "No," Primary Spoken Language: _____ Primary Written Language: _____	
Did you complete this application? ☐ Yes ☐ No (If "No", you must complete the Statement of Accountability.)	
Statement of Accountability – Must be completed if the applicant answered "No" to read or write English or the applicant did not complete this application. I _____, acting as (describe your relationship) _____ have personally read this form to the applicant and completed the application because: ☐ Applicant does not have sufficient command of the English language to complete this application ☐ Applicant is legally incapacitated and unable to complete this application I have read and explained in detail the contents of this application. _____ If translated, I also fully explained to the applicant the "Authorization to Disclose Personal Health Information" and "Signature(s) Required" under **Sections F and H**.	
Signature of Representative ***(Required)***	Today's Date ***(Required)***
Print Name	
Street Address	

City	State	ZIP Code	Telephone Number ( )

Primary Applicant's Name

Section F – Authorization to Use and Disclose Protected Health Information

Please read the following carefully before completing your authorization. You may refuse to sign this authorization.

Purposes of this Authorization Form
By signing this form, I authorize HealthAmerica, or HealthAmerica's representatives, to pay a fee to a third party for certain protected health information (PHI) about me, including but not limited to, prescribed medication history or other pharmaceutical information, hospital records, physician and/or dentist records, claims or benefit records or lab results. The PHI purchased by HealthAmerica may be used for the following purposes: a) to coordinate medical care and case management, and/or b) for risk adjustment activities.

PHI purchased by HealthAmerica may be related to chronic diseases, mental illness, alcohol or substance abuse, Human Immunodeficiency Virus (HIV) infection, or Acquired Immune Deficiency Syndrome (AIDS).

I authorize HealthAmerica to disclose my PHI for the purposes stated above to other persons or organizations performing services on HealthAmerica's behalf.

HealthAmerica may not condition your treatment, payment, enrollment or eligibility for benefits, on whether or not you sign this authorization.

Health information received by HealthAmerica will not be re-disclosed without your authorization unless permitted by law, as described in HealthAmerica's Notice of Privacy Practices. Information that is re-disclosed may not be protected under federal privacy laws.

Term of Authorization
I agree this Authorization shall be valid for eighteen (18) months from the signature date below.

Right to Revoke
I understand that I may revoke this authorization at any time by giving written notice to HealthAmerica using the address provided in Section J. My revocation will not have any effect on actions HealthAmerica has already taken before receiving my notice.

Primary Applicant's or Parent/Guardian's Signature	Date
Spouse / Domestic Partner's Signature	Date
Dependent's signature (age 18 or older)	Date
Dependent's signature (age 18 or older)	Date

Primary Applicant's Name

Section G – Payment Options (Select the method of payment for your initial application and following premium payments.)

Initial Payment

☐ Electronic Fund Transfer (complete the EFT information below)

Recurring or Follow Up Payments

☐ Electronic Fund Transfer (complete the EFT information below)

Payroll Deduction Program (PDP) / Employer List Bill (ELB)

This program allows your premium to be deducted directly from your paycheck, on a post-tax basis. Other details apply. To choose this option, you MUST submit a separate Payroll Deduction Authorization Form with your application.

☐ New Payroll Deduction Program (PDP) / Employer List Bill (ELB)

☐ Existing Payroll Deduction Program (PDP) / Employer List Bill (ELB)

ELB Number: _____

ELB Name: _____

Electronic Fund Transfer – EFT

Upon issuance, the first month's premium will automatically be withdrawn from the listed bank account. The following monthly premiums will be withdrawn automatically from the bank account listed on the application on the 5th day (or the following business day if a weekend or holiday) in the month for which premium is due. The premium amount due is calculated per day, so if the effective date is anything other than the 1st of the month, the following premium payment will be prorated.

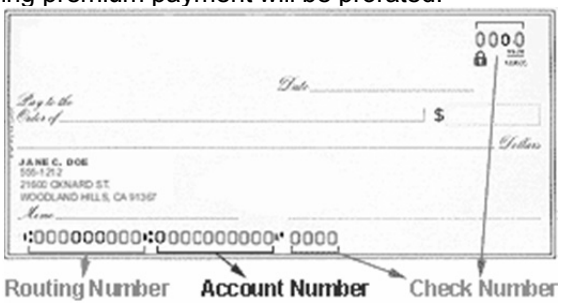
Account Number: _____

Routing Number: ☐☐☐☐☐☐☐☐☐

Name(s) on Account: _____

Account Holder Address: _____

☐ Checking ☐ Savings



Any rate adjustment made in accordance with the enrollment process will be automatically charged to your account upon approval of your application. Please be advised that tobacco use may result in an increase to the standard premium.

Important Note: HealthAmerica *One* is not an employer-sponsored group health plan. If your banking information is from a business account, or you are submitting a check drawn from a business account, you must contact us / your agent to complete a HealthAmerica *One* Payroll Deduction / Employer List Bill (ELB) Authorization Form.

By signing this Premium Payment section, you are agreeing to the following statements:

- You understand that it is your responsibility to immediately notify HealthAmerica at 1-866-874-2624 should your payment or address information change at any time while you continue to hold a HealthAmerica *One* policy.
- You understand that if premium payment is returned unpaid, a fee will be assessed in the amount of $20.00. Failure to remit the first payment could result in rescission back to your effective date.
- You understand that providing this payment information does not guarantee approval for coverage.
- Upon issuance of this Application, you authorize HealthAmerica to initiate an immediate automatic withdrawal and / or a billing cycle of applicable premium payments from your provided account or billing information. If your effective date is entered into the system after the third business day of the month, your following automatic withdrawal may include premium amounts for multiple months.
- I agree this authorization will remain in effect until I provide written notification terminating this service.

Account / Card Holder Signature	**Date**

Primary Applicant's Name

Section H – Signature(s) Required – All Applicants (Primary/Spouse and dependents) age 18 and older must read and sign this form below.

By signing this form you agree to the following:

1. The answers in this application are true and complete to the best of my knowledge and belief.
2. The children listed on this application are my legal dependents.
3. I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by HealthAmerica, and may face legal liability, including legal action based on fraud.
4. I have read this entire application, or it has been read to me.
5. The information I have provided in this application will be used by HealthAmerica to determine whether to issue coverage and the premium amount for such coverage.
6. No coverage shall be in force until HealthAmerica processes this application and HealthAmerica has notified me of my effective date.
7. This application will become part of the contract between HealthAmerica and me.
8. I or my legal representative has the right to receive a copy of this application upon request. I agree that a photocopy shall be as valid as the original. A legal facsimile signature shall have the same force and effect as the original.
9. I authorize HealthAmerica to electronically transmit the information contained in this application.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Primary Applicant's or Parent/Guardian's Signature	Date
Spouse / Domestic Partner's Signature	Date
Dependent's signature (age 18 or older)	Date
Dependent's signature (age 18 or older)	Date

Primary Applicant's Name

Section I – Insurance Producer or Agent (Required If Applicable)

Complete if Broker of Record is an Individual Producer (not an Agency)

Print Name of Producer	NPN of Agent
Signature of Producer (required if applicable)	Telephone Number ( )
E-mail Address	Fax Number ( )
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	

Complete if Broker of Record is an Agency

Name of Agency	TIN of Agency	
E-mail Address	Telephone Number ( )	Fax Number ( )
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)		
Print Name of Producer Representing Agency	NPN Number	
Signature of Agency Representative (required if applicable)		

General Agent

Print Name of General Agent	TIN of General Agent
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	

HealthAmerica Sales Representative

Last Name of Agent (Print Name)	First Name of Agent (Print Name)	License Number

Section J – Contact Information

Please return this application to the agent or submit to the address listed below.

HealthAmerica Individual Plans
PO Box 31217
Tampa, FL 33631-3217

Fax #: 877-904-7822
E-mail: cvtynewapps@healthplan.com
Website for information: www.coventryone.com