HealthAmericaOne. A Coventry Health Care Plan

Underwritten by HealthAmerica Pennsylvania, Inc.

Submit completed Application for Health Coverage to:
HealthAmerica Pennsylvania
P.O. Box 31217
Tampa, FL 33631-3217
or email:
cvtynewapps@healthplan.com
or by fax at:
1-877-904-7822

HealthAmerica Pennsylvania, Inc.

Application for Health Coverage

Important: Please print clearly in BLACK ink as instructed in each section. Initial and date corrections; correction fluid is not permitted. Read and sign the Acknowledgements Section.

NOTICE - 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.

Check all that apply:

☐ New Application ☐ Add a Dependent ☐ Product Benefits Change ☐ Child-Only Application (under 19 years old)

☐ Qualifying Life Event *(Only individuals experiencing a Qualifying Life Event are eligible for enrollment outside of the annual open enrollment period)*

Please list your Qualifying Life Event: _____

Product Choice

Choose one (1) product only. If other individuals applying for coverage wish to apply for different products, a separate Application must be used.

Gold	Silver	Bronze	Catastrophic
☐ Gold $5 Copay HMO Plan	☐ Silver $10 Copay HMO Plan	☐ Bronze $10 Copay HMO Plan ☐ Bronze Deductible Only HMO HSA Eligible Plan	☐ Catastrophic 100% HMO Plan

Health Savings Account (HSA) Selection If you have selected the Bronze Deductible Only PPO HSA Eligible Plan you are eligible to open a Health Savings Account (HSA) through our HSA trustee, HealthEquity, at no additional cost.

☐ I elect to have an HSA opened through HealthEquity

Requested Effective Date The Effective Date will be assigned by Coventry based on the date of receipt of a completed application.

___ / ___ / _____ (mm/dd/yyyy)	Premium for the selected Product Choice: $_____ / Month ☐ Individual ☐ Family Note: This premium will only be effective for the current calendar year through December 31.

Primary Applicant Name: _____ Agent Name: _____

Primary Applicant Information

Please provide information on the Primary Applicant. If applying for Child-Only coverage, please fill in the parent or legal guardian's information below.

Last Name	First Name			MI	County

Home Address *(not P.O. Box)*	City	State	Zip	Relationship *(if Child-Only Application)*

Mailing Address *(If different from address above)*	City	State	Zip	Phone Number ☐ Home ( ) - ☐ Work ( ) - ☐ Mobile ( ) -

E-mail Address	☐ If available, I would like to get information by Text.
☐ Check here to consent to receiving your policy and other pertinent documents by e-mail only	

☐ Check here to consent to receiving your Explanation(s) of Benefits (EOB) by e-mail

☐ Check here to receive emails about tools and programs to help stay healthy

☐ Check here to receive emails about tools, information and promotions to help manage health care costs and learn about new products

Primary Language (*if other than English*): ☐ Spanish (Español) ☐ Navajo (Dine) ☐ Chinese (中文) ☐ Tagalog (Tagalog) ☐ Other _____

Existing / Prior Insurance Coverage

Does any individual applying for coverage currently have or had any health insurance coverage in the past 2 years?	☐ Yes ☐ No

Effective Date	Termination Date	Name of Persons Insured

Will the existing policy remain in effect?	☐ Yes ☐ No
Does any individual applying for coverage currently have or had any dental insurance coverage in the past 2 years?	☐ Yes ☐ No

Effective Date	Termination Date	Name of Persons Insured

Will the existing policy remain in effect?	☐ Yes ☐ No

Applicant and Dependent Information

General Information List all individuals applying for health coverage in this section. For a Child-Only Application, begin listing child(ren) on Line 3 with the youngest child listed first. If you need more space, attach a separate sheet of paper with the details in the same format as the box below. Sign and date any attachments.

1 Primary Applicant (blank if Child-Only)			
Last Name	First Name	MI	Tobacco use in past 6 months?[1] ☐ Yes ☐ No
SSN	Birthdate (mm/dd/yyyy)	M/F	U.S. residency for past 6 months?[2] ☐ Yes ☐ No*
2 Spouse (blank if Child-Only)			
Last Name	First Name	MI	Tobacco use in past 6 months?[1] ☐ Yes ☐ No
SSN	Birthdate (mm/dd/yyyy)	M/F	U.S. residency for past 6 months?[2] ☐ Yes ☐ No*
Home Address (if different from Primary Applicant)			Relationship to Primary Applicant
3 Dependent Child or Child-Only			
Last Name	First Name	MI	Tobacco use in past 6 months?[1] ☐ Yes ☐ No
SSN	Birthdate (mm/dd/yyyy)	M/F	U.S. residency for past 6 months?[2] ☐ Yes ☐ No*
Home Address (if different from Primary Applicant)			Relationship to Primary Applicant
4 Dependent Child or Child-Only			
Last Name	First Name	MI	Tobacco use in past 6 months?[1] ☐ Yes ☐ No
SSN	Birthdate (mm/dd/yyyy)	M/F	U.S. residency for past 6 months?[2] ☐ Yes ☐ No*
Home Address (if different from Primary Applicant)			Relationship to Primary Applicant
5 Dependent Child or Child-Only			
Last Name	First Name	MI	Tobacco use in past 6 months?[1] ☐ Yes ☐ No
SSN	Birthdate (mm/dd/yyyy)	M/F	U.S. residency for past 6 months?[2] ☐ Yes ☐ No*
Home Address (if different from Primary Applicant)			Relationship to Primary Applicant
6 Dependent Child or Child-Only			
Last Name	First Name	MI	Tobacco use in past 6 months?[1] ☐ Yes ☐ No
SSN	Birthdate (mm/dd/yyyy)	M/F	U.S. residency for past 6 months?[2] ☐ Yes ☐ No*
Home Address (if different from Primary Applicant)			Relationship to Primary Applicant
7 Dependent Child or Child-Only			
Last Name	First Name	MI	Tobacco use in past 6 months?[1] ☐ Yes ☐ No
SSN	Birthdate (mm/dd/yyyy)	M/F	U.S. residency for past 6 months?[2] ☐ Yes ☐ No*
Home Address (if different from Primary Applicant)			Relationship to Primary Applicant

[1] 'Tobacco use' constitutes use of any tobacco products (excluding the religious or ceremonial use of tobacco) four or more times per week on average within no longer than the past 6 months. [2] 'U.S. residency" refers to the designated individual living legally in the United States for the past six (6) months. * If you have answered "No", you will not be covered under this policy.

For Coventry*One* Health Maintenance Organization (HMO) products, the provider must be within our network. A list of participating providers can be found at the health plan's website http://pa.coventryproviders.com.

Primary Applicant Name: _____ Agent Name: _____

Acknowledgements

By signing this Application form, I, the Applicant, including any undersigned Spouse and Dependents, agree to the following statements:

- I understand that the selling agent (if applicable) has no authority to promise coverage to the applicant or any individual applying for coverage, or to modify HealthAmerica's eligibility criteria, effective date of coverage or terms of coverage.
- I understand that the information that I provide on this Application will be used to determine eligibility for health insurance coverage for which I am applying. I attest that my Application responses are complete and accurate to the best of my knowledge.
- I understand that if any material information is omitted or misrepresented from any section of the Application, coverage may be refused, terminated, or rescinded, at HealthAmerica's sole discretion. HealthAmerica may rescind coverage only in cases of fraud or intentional misrepresentation of a material fact. In the event that coverage is rescinded, the policy will be voided back to the original effective date and all premium payments will be refunded. HealthAmerica shall not be financially liable for any health care services rendered prior to the rescission.
- I agree to notify HealthAmerica in writing if I or any individual applying for health insurance coverage has any changes to the answers or statements provided on this Application between the date this Application is signed and the effective date or approval date of coverage, whichever is later. My failure to provide HealthAmerica with this updated health information may result in a change of rate, denial or rescission of coverage.

DO NOT cancel your existing health coverage until HealthAmerica has notified you in writing that your coverage with HealthAmerica is effective. Please retain a copy of this application for your records.

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.

Primary Applicant's Signature	Date	Spouse's Signature (if applying for coverage)	Date
Dependent Signature[1]	Date	Dependent Signature[1]	Date

The below signatures must be completed if this is a Child-Only Application or if any child applying for health coverage (under the age of 18) has a Custodial Parent[2] that is not the Primary Applicant or Spouse of the Primary Applicant.

Parent/Legal Guardian Signature	Print Name	Relationship to individual applying for coverage	Date
Custodial Parent Signature[2]	Print Name	Name of child(ren) to whom this applies	Date

[1]Dependent Signature is required for individuals applying for coverage ages 18 and over
[2]The Custodial Parent is the person with physical or legal custody of a child under 18 years of age.

FOR AGENT USE ONLY

Agent 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 any individual applying for coverage to withhold any information regarding the answers to the questions and have advised the individuals applying for coverage to review the Application and the answers recorded to confirm completeness and accuracy. I further attest that all my answers recorded in this application are correct, complete, and wholly true to the best of my knowledge and belief.

Agent Name	Agent ID #	Agent E-mail
Agency Name	Agent / Agency Phone	Name of General Agent
Payee (who is paid commissions) ☐ Agent ☐ Agency ☐ General Agent		Payee Tax ID#
Agent Signature		Date

Primary Applicant Name: _____ Agent Name: _____

Premium Payment

Initial Premium Payment Options Choose ONE payment option for initial payment. You must then complete the applicable section regarding your account information.

☐ EFT

Ongoing Premium Payment Options Choose ONE payment option for ongoing payment. You must then complete the applicable section regarding your account information.

☐ Monthly EFT (no administrative fee)

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 Employer List Bill (ELB) ELB number: _____ ELB name: _____

EFT (Electronic Funds Transfer) Information Complete this section if you have chosen to pay by EFT. The first month's premium will automatically be withdrawn from the listed bank account upon issuance. 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.

☐ Checking Account ☐ Savings Account	Name of Account Holder	9-digit routing number	Account Number
Name of Bank / Savings Institution		Relationship of Account Holder to Primary Applicant ☐ Self ☐ Spouse ☐ Other_____	
Account Holder Address		City	State / Zip
Token		Account Number (Last 4 digits)	

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 (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 Name: _____ Agent Name: _____