

SERFF Tracking Number: CLTR-126072429 State: Arkansas
Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 41815
Company Tracking Number: CHL-CW-EOI-001
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: Life Insurance Health Questionnaire
Project Name/Number: CHL-CW-EOI-001/CHL-CW-EOI-001

Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: Life Insurance Health SERFF Tr Num: CLTR-126072429 State: Arkansas

Questionnaire

TOI: L04G Group Life - Term

SERFF Status: Closed-Approved- State Tr Num: 41815
Closed

Sub-TOI: L04G.500 Other

Co Tr Num: CHL-CW-EOI-001 State Status: Approved-Closed
Reviewer(s): Linda Bird

Filing Type: Form

Authors: Frank Cripps, Karen Pollitt, Disposition Date: 03/18/2009
Susan Kalmus

Date Submitted: 03/12/2009 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: CHL-CW-EOI-001

Status of Filing in Domicile: Pending

Project Number: CHL-CW-EOI-001

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 03/18/2009

Explanation for Other Group Market Type:

State Status Changed: 03/18/2009

Deemer Date:

Created By: Susan Kalmus

Submitted By: Susan Kalmus

Corresponding Filing Tracking Number:

Filing Description:

The attached Questionnaire is being submitted on behalf of Coventry Health and Life Insurance Company. This form is new and will not replace any other form on file with your Department.

On October 16, 2008 the Department Approved group term life policy form CHL-CW-Life Policy-0001 and related forms (SERFF Tracking No. CLTR-125845858; State Tracking No. 40497J).

Enclosed please find Coventry Health and Life Insurance Company's (CHL) Life Insurance Health Questionnaire, form

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CHL-CW-EOI-001. This Questionnaire will be used to gather basic health history information from applicants requesting coverage in an amount that exceeds the guaranteed issue amount (usually \$150,000) for purposes of evaluating applicant insurability for the coverage above the guaranteed issue limit.

The form includes a release to enable CHL to gather any additional medical information necessary to this evaluation of insurability.

Currently, this form would only apply to CHL's large group segment (>50 employees). The bracketed language in Section 2 of the form is to enable evidence of insurability analysis of an off-cycle applicant without a qualifying event, should CHL decide to allow such applications in either the small or large group segments.

We trust you will find this submission to be complete.

Company and Contact

Filing Contact Information

Susan Kalmus, Consultant susank@coulter-and-associates.com
C/O Coulter & Associates, Inc 609-443-7540 [Phone]
379 Princeton-Hightstown Road 609-443-4103 [FAX]
Suite 15
Cranbury, NJ 08512

Filing Company Information

(This filing was made by a third party - coulterandassociatesinc)

Coventry Health and Life Insurance Company CoCode: 81973 State of Domicile: Delaware
6705 Rockledge Drive Group Code: Company Type: Life
Bethesda, MD 20817 Group Name: State ID Number:
(301) 581-5648 ext. [Phone] FEIN Number: 75-1296086

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation: delaware is \$50 per form
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Coventry Health and Life Insurance Company	\$50.00	03/12/2009	26364764

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/18/2009	03/18/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Evidence of Insurability	Frank Cripps	03/16/2009	03/16/2009

SERFF Tracking Number: CLTR-126072429 *State:* Arkansas
Filing Company: Coventry Health and Life Insurance Company *State Tracking Number:* 41815
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Disposition

Disposition Date: 03/18/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CLTR-126072429 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Authorization		Yes
Form (revised)	Evidence of Insurability		Yes
Form	Evidence of Insurability	Replaced	Yes

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Amendment Letter

Submitted Date: 03/16/2009

Comments:

We are replacing the originally submitted form with a corrected form. We apologize for any inconvenience.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
CHL-CW-EOI-001	Application/Enrollment Form	Evidence of Insurability	Initial					CHL-CW-EOI-001 evidence of insurability form.pdf

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Form Schedule

Lead Form Number: CHL-CW-EOI-001

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	CHL-CW-EOI-001	Application/Evidence of Enrollment Insurability Form	Initial			CHL-CW-EOI-001 evidence of insurability form.pdf



Life Insurance Health Questionnaire - Please Print Clearly

Products are underwritten by Coventry Health and Life Insurance Company

SECTION 1 Employer Details		
Employer Name:		
Group Number:	Policy Number:	
SECTION 2 Requested Coverage Information		
Applicant's Requested Coverage Amount	\$	
Purpose of this Life Insurance Health Questionnaire:		
<input type="checkbox"/> Coverage requested exceeds Guaranteed Issue amount of \$ _____ <input type="checkbox"/> Coverage is being requested outside of Open Enrollment without Qualifying Event]		
SECTION 3 Employee's Information		
Employee's Name: (Last, First Middle Initial)	Employee's Social Security Number: - -	
SECTION 4 Applicant's Information		
Applicant's Name: (Last, First Middle Initial) Check this box if the employee is the applicant <input type="checkbox"/>	Applicant's Social Security Number: - -	
Applicant's Height / _____ ft _____ in / _____ lbs Weight	Applicant's Gender (M/F):	Applicant's Date of Birth (MM/DD/YYYY) / /
Mailing Address (Street, Apt#):		
City:	State:	Zip Code:
Daytime Phone: () -		Evening Phone: () -
SECTION 5 Medical Information		
If you can answer Yes to any of the Questions below, check the appropriate box and provide additional details in Section 6.		
1. Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 work days for the same physical, mental, or emotional condition, disability, injury, or sickness?	<input type="checkbox"/>	
2. Within the past 5 years, have you used any controlled substances, with the exception of those prescribed by your physician, received medical advice or sought treatment for drug or alcohol abuse, or been charged with operating a motor vehicle under the influence of drugs or alcohol?	<input type="checkbox"/>	
3. Are you currently undergoing any diagnostic testing for symptoms without a final diagnosis or resolution?	<input type="checkbox"/>	
4. Are you currently pregnant? If yes, what was your pre-pregnancy weight? _____ lbs	<input type="checkbox"/>	
5. During the past 5 years have you been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune deficiency disorder?	<input type="checkbox"/>	

6. During the past 5 years have you been diagnosed with, treated for, treated with, or had any symptoms due to any of the following conditions or treatments listed below? Please check all that apply:			
Heart-Related Surgery or Heart Attack	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Kidney Failure/Dialysis	<input type="checkbox"/>
Heart Disease (excluding high blood pressure & heart murmur)	<input type="checkbox"/>	Hepatitis (excluding Hepatitis A)	<input type="checkbox"/>
Blocked Arteries (including arteriosclerosis, atherosclerosis, aneurysm, or deep vein blood clot)	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Chronic Obstructive Pulmonary Disorder (COPD)	<input type="checkbox"/>	Knee Disorder, Injury, or Surgery	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	Back or Neck Disorder, Injury, or Surgery	<input type="checkbox"/>
Adjustment Disorder	<input type="checkbox"/>	Joint/Ligament Disorder, Injury, or Surgery	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	Osteoporosis or Osteopenia	<input type="checkbox"/>
Depression (single episode)	<input type="checkbox"/>	Multiple Sclerosis (MS)	<input type="checkbox"/>
Depression (multiple episodes)	<input type="checkbox"/>	Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/>
Psychotic/Personality Disorders	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>
Other Mental/Nervous/Psychiatric Disorders (including Anxiety)	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Cancer (excluding Basal Cell Carcinoma)	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>	Chronic Fatigue Syndrome	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>
7. Has any member of your family been diagnosed with, treated for, treated with, or had any symptoms due to any of the conditions or treatments listed above?			<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you pursue hobbies that could be considered dangerous? (for example, hang gliding, BASE jumping, bungee jumping, sky diving...)			<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 6 Additional Details

Please Print Clearly

Question # or Condition	Applicant Name	Medications/Treatment	Date of Diagnosis	Date of Last Symptom	Current Status of Condition	Physician's Name, Address, Phone #

Question # or Condition	Applicant Name	Medications/Treatment	Date of Diagnosis	Date of Last Symptom	Current Status of Condition	Physician's Name, Address, Phone #

Hobbies:

SECTION 7 Fraud Notice

General: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

Arkansas: 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 is guilty of a crime and may be subject to fines and confinement in prison.

Florida: 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 is guilty of a felony of the third degree.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Louisiana: 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 is guilty of a crime and may be subject to fines and confinement in prison.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.



SECTION 8 Health Questions Certification Statement

I represent that all information on this Life Insurance Health Questionnaire 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 as applicable, or refund any premiums paid as though coverage had never been in force within the contestable period as set forth in applicable state law. 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 Health and Life Insurance Company of such in writing. I understand that failure to do so may result in the denial, reformation or rescission of coverage.

APPLICANT'S SIGNATURE

DATE

SECTION 9 AUTHORIZATION OF RELEASE OF INFORMATION

I 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 and Life Insurance Company ("CHL") or its authorized representatives, my 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 CHL to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by CHL for the purpose of evaluating my application for life insurance. Further, I understand that my authorization is required for CHL to consider my application for life insurance and to determine whether or not an offer of coverage will be made. No action will be taken on my application for life insurance without my signed authorization. I understand information obtained with my authorization may be re-disclosed by CHL 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 CHL to use or disclose the information I provide in this Life Insurance Health Questionnaire (or that CHL has or receives from third parties) for purposes of administering my life 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 CHL prior to the date such revocation is received by CHL.

These authorizations will be valid for 24 months beginning on the date it is signed by the Applicant.

APPLICANT'S SIGNATURE

DATE

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Eol Flesch Certification.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: Policy not submitted at this time. Policy and application approved on 10/18/2008. Comments:		

	Item Status:	Status Date:
Satisfied - Item: Authorization Comments: Attachment: Authorization Letter.pdf		



6705 Rockledge Drive, Bethesda, Maryland 20817 • (301) 581-5648

CERTIFICATION OF COMPLIANCE
FOR
READABILITY

<u>Form Number(s)</u>	<u>Description</u>	<u>Flesch Readability Score</u>
CHL-CW-EOI-001	Evidence of Insurability Form	43.3

I hereby certify on behalf of BCS Life Insurance Company that the Flesch Scale Analysis Readability Score is accurate, based on the computer program used to calculate the scores. I further certify that in my judgment, the enclosed forms are readable under the rules and standards of your State.

For Coventry Health and Life Insurance Company

A handwritten signature in black ink, appearing to read "Shirley Smith".

Shirley Smith
Vice President and Secretary



October 1, 2008

All State Insurance Departments

Re: Authorization to File Life Insurance Products

To Whom It May Concern:

This is to inform you that **Coulter & Associates**, 379 Princeton-Hightstown Road, Suite 15, Cranbury, New Jersey 08512, has been retained to act on our behalf as indicated herein.

Coulter & Associates is hereby empowered to act for Coventry Health and Life Insurance Company in any governmental jurisdiction of the United States in matters regarding the filing of life insurance products, forms, rates, and advertising materials, and any other material incidental to the acceptance of such filings.

Your cooperation in working with Coulter and Associates is greatly appreciated.

This authorization shall be effective until such time as we notify you otherwise.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Shirley Smith'.

Shirley Smith
Vice President and Secretary

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Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/12/2009	Form	Evidence of Insurability	03/16/2009	CHL-CW-EOI-001 evidence of insurability form.pdf (Superseded)



Life Insurance Health Questionnaire - Please Print Clearly

Products are underwritten by Coventry Health and Life Insurance Company

SECTION 1 Employer Details		
Employer Name:		
Group Number:	Policy Number:	
SECTION 2 Requested Coverage Information		
Applicant's Requested Coverage Amount	\$	
Purpose of this Life Insurance Health Questionnaire:		
<input type="checkbox"/> Coverage requested exceeds Guaranteed Issue amount of \$ _____ <input type="checkbox"/> Coverage is being requested outside of Open Enrollment without Qualifying Event]		
SECTION 3 Employee's Information		
Employee's Name: (Last, First Middle Initial)	Employee's Social Security Number: - -	
SECTION 4 Applicant's Information		
Applicant's Name: (Last, First Middle Initial)	Applicant's Social Security Number: - -	
Check this box if the employee is the applicant <input type="checkbox"/>		
Applicant's Height / _____ ft _____ in / _____ lbs	Applicant's Gender (M/F):	Applicant's Date of Birth (MM/DD/YYYY) / /
Mailing Address (Street, Apt#):		
City:	State:	Zip Code:
Daytime Phone: () - _____	Evening Phone: () - _____	
SECTION 5 Medical Information		
If you can answer Yes to any of the Questions below, check the appropriate box and provide additional details in Section 6.		
1. Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 work days for the same physical, mental, or emotional condition, disability, injury, or sickness?	<input type="checkbox"/>	
2. Within the past 5 years, have you used any controlled substances, with the exception of those prescribed by your physician, received medical advice or sought treatment for drug or alcohol abuse, or been charged with operating a motor vehicle under the influence of drugs or alcohol?	<input type="checkbox"/>	
3. Are you currently undergoing any diagnostic testing for symptoms without a final diagnosis or resolution?	<input type="checkbox"/>	
4. Are you currently pregnant? If yes, what was your pre-pregnancy weight? _____ lbs	<input type="checkbox"/>	
5. During the past 5 years have you been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune deficiency disorder?	<input type="checkbox"/>	

6. During the past 5 years have you been diagnosed with, treated for, treated with, or had any symptoms due to any of the following conditions or treatments listed below? Please check all that apply:			
Heart-Related Surgery or Heart Attack	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Kidney Failure/Dialysis	<input type="checkbox"/>
Heart Disease (excluding high blood pressure & heart murmur)	<input type="checkbox"/>	Hepatitis (excluding Hepatitis A)	<input type="checkbox"/>
Blocked Arteries (including arteriosclerosis, atherosclerosis, aneurysm, or deep vein blood clot)	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Chronic Obstructive Pulmonary Disorder (COPD)	<input type="checkbox"/>	Knee Disorder, Injury, or Surgery	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	Back or Neck Disorder, Injury, or Surgery	<input type="checkbox"/>
Adjustment Disorder	<input type="checkbox"/>	Joint/Ligament Disorder, Injury, or Surgery	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	Osteoporosis or Osteopenia	<input type="checkbox"/>
Depression (single episode)	<input type="checkbox"/>	Multiple Sclerosis (MS)	<input type="checkbox"/>
Depression (multiple episodes)	<input type="checkbox"/>	Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/>
Psychotic/Personality Disorders	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>
Other Mental/Nervous/Psychiatric Disorders (including Anxiety)	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Cancer (excluding Basal Cell Carcinoma)	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>	Chronic Fatigue Syndrome	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>
7. Has any member of your family been diagnosed with, treated for, treated with, or had any symptoms due to any of the conditions or treatments listed above?			<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you pursue hobbies that could be considered dangerous? (for example, hang gliding, BASE jumping, bungee jumping, sky diving...)			<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 6 Additional Details

Please Print Clearly

Question # or Condition	Applicant Name	Medications/Treatment	Date of Diagnosis	Date of Last Symptom	Current Status of Condition	Physician's Name, Address, Phone #

Question # or Condition	Applicant Name	Medications/Treatment	Date of Diagnosis	Date of Last Symptom	Current Status of Condition	Physician's Name, Address, Phone #

Hobbies:

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Florida: 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 is guilty of a felony of the third degree.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Louisiana: 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 is guilty of a crime and may be subject to fines and confinement in prison.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.



SECTION 8 Health Questions Certification Statement

I represent that all information on this Life Insurance Health Questionnaire 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 as applicable, or refund any premiums paid as though coverage had never been in force within the contestable period as set forth in applicable state law. 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 Health and Life Insurance Company of such in writing. I understand that failure to do so may result in the denial, reformation or rescission of coverage.

APPLICANT'S SIGNATURE

DATE

SECTION 9 AUTHORIZATION OF RELEASE OF INFORMATION

I 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 and Life Insurance Company ("CHL") or its authorized representatives, my 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 CHL to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by CHL for the purpose of evaluating my application for life insurance. Further, I understand that my authorization is required for CHL to consider my application for life insurance and to determine whether or not an offer of coverage will be made. No action will be taken on my application for life insurance without my signed authorization. I understand information obtained with my authorization may be re-disclosed by CHL 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 CHL to use or disclose the information I provide in this Life Insurance Health Questionnaire (or that CHL has or receives from third parties) for purposes of administering my life 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 CHL prior to the date such revocation is received by CHL.

APPLICANT'S SIGNATURE

DATE