

SERFF Tracking Number: GHPI-126513145 State: Arkansas  
Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 44969  
Company Tracking Number: ARAPP10  
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)  
Product Name: ARAPP10  
Project Name/Number: /

## Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: ARAPP10

SERFF Tr Num: GHPI-126513145 State: Arkansas

TOI: H16I Individual Health - Major Medical

SERFF Status: Closed-Approved-  
Closed State Tr Num: 44969

Sub-TOI: H16I.005A Individual - Preferred  
Provider (PPO)

Co Tr Num: ARAPP10

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Geneva Clark, Anita  
Carter

Disposition Date: 03/02/2010

Date Submitted: 02/23/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 03/02/2010

Explanation for Other Group Market Type:

State Status Changed: 03/02/2010

Deemer Date:

Created By: Anita Carter

Submitted By: Anita Carter

Corresponding Filing Tracking Number:

Filing Description:

(314) 506-1928

acarter@cvty.com

February 23, 2010

Rosalind Minor

SERFF Tracking Number: GHPI-126513145 State: Arkansas  
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(PPO)

Product Name: ARAPP10

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Sr. Certified Rate & Form Analyst  
Arkansas Insurance Department  
Life and Health Division  
1200 West Third Street  
Little Rock, Arkansas 72201

Re: Co Tracking #: ARAPP10  
Form #: CHARK 00012-1  
Application for Health Coverage

Dear Ms Minor:

I am writing on behalf of Coventry Health and Life Insurance Co. ("CHL") regarding submission of the above referenced document.

The intended market for this document is the individual market. This document is a new, rather than replacement document. This document will be issued to individuals.

In addition, please note the following:

1. A check in the amount of \$20.00 will be sent under separate cover as per our email discussion on September 25, 2008 for this filing.
2. In compliance with ACA 23-79-206, a Readability Certificate is attached.
3. In compliance with Rule & Regulation 19, this document does not discriminate on the basis of sex.

Thank you for your assistance with this filing. If you have any comments or concerns, please contact me at (314) 506-1928.

Sincerely,

Anita J. Carter, RN  
Manager, Regulatory Compliance

## Company and Contact

### Filing Contact Information

Anita Carter, Manager of Regulatory Compliance      acarter@cvty.com

SERFF Tracking Number: GHPI-126513145 State: Arkansas  
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Project Name/Number: /

550 Maryville Centre Drive 314-506-1928 [Phone]  
Suite 300 314-506-1672 [FAX]  
St. Louis, MO 63141-5818

### Filing Company Information

Coventry Health and Life Insurance Company CoCode: 81973 State of Domicile: Delaware  
6705 Rockledge Drive Group Code: 1137 Company Type:  
Suite 900 Group Name: State ID Number:  
Bethesda, MD 20817 FEIN Number: 75-1296086  
(314) 506-1700 ext. [Phone]

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### Filing Fees

Fee Required? No  
Retaliatory? No  
Fee Explanation:  
Per Company: No

SERFF Tracking Number: GHPI-126513145 State: Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/02/2010	03/02/2010

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	02/24/2010	02/24/2010	Anita Carter	02/26/2010	02/26/2010

*SERFF Tracking Number:* GHPI-126513145      *State:* Arkansas  
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(PPO)  
*Product Name:* ARAPP10  
*Project Name/Number:* /

## **Disposition**

Disposition Date: 03/02/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.



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(PPO)  
Product Name: ARAPP10  
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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/24/2010  
Submitted Date 02/24/2010

Respond By Date

Dear Anita Carter,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application for Health Coverage, CHARK 00012-1 (Form)

Comment:

On the first page of the application, the name of the actual insurer/underwriter of the policy and forms must not be so small as to mislead the consumer on the true identity of the insurer. the name of the insurer needs to be in close conjunction and in the same size type as the letters, initials or symbols as Coventry One.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 02/26/2010  
Submitted Date 02/26/2010

Dear Rosalind Minor,

### Comments:

In response to your objection letter dated 2/24/10, please note the following.

### Response 1

Comments: The name of the insurer/underwriter of the policy on this filing has been revised to the same type and size as Coventry One. Please see the red-lined version showing the change attached your convenience.

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**Related Objection 1**

Applies To:  
 - Application for Health Coverage, CHARK 00012-1 (Form)  
 Comment:

On the first page of the application, the name of the actual insurer/underwriter of the policy and forms must not be so small as to mislead the consumer on the true identity of the insurer. the name of the insurer needs to be in close conjunction and in the same size type as the letters, initials or symbols as Coventry One.

**Changed Items:**

**Supporting Document Schedule Item Changes**

Satisfied -Name: Application-red-line 02/26/10  
 Comment: Attached is the red-line version of this document showing the changes as per the objection letter dated 2/24/10.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Application for Health Coverage	CHARK 00012-1		Application/Enrollment Form	Initial			CHARK 00012-1.pdf

**Previous Version**

Application for Health Coverage	CHARK 00012-1		Application/Enrollment Form	Initial			CHARK 00012-1.pdf
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No Rate/Rule Schedule items changed.

Thank you for your assistance with this filing. Should you have any further concerns or questions, please do not hesitate to call me at 314-506-1928.

Sincerely,  
 Anita Carter, Geneva Clark

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## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	CHARK 00012-1	Application/Enrollment Form	Application for Health Coverage	Initial			CHARK 00012-1.pdf
	03/02/2010						



## 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.

Full Name (Last, First, MI)	Social Security Number <sup>[1]</sup>	Birthdate (mm/dd/yyyy)	Gender (M or F)	Height (ft. in.)	Weight (lbs.)	Tobacco use in past 12 months? <sup>[2]</sup>	U.S. residency for past [6 months / 2 years]? <sup>[3]</sup>
1 Primary Applicant (blank if Child-Only)						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2 Spouse (blank if Child-Only)						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
3 Dependent Child or Child-Only						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
4 Additional Child						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
5 Additional Child						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
6 Additional Child						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							

[<sup>1</sup>Not required in <State>]. [<sup>2</sup> 'Tobacco use' constitutes use of tobacco or tobacco cessation products in the past twelve (12) months. <sup>3</sup> 'U.S. residency' refers to the designated individual living [legally] in the United States for the past [6 months/2 years].

<b>1 Prior Insurance Coverage</b>	
Has any individual applying for coverage had any health insurance coverage in the past 2 years? If "Yes," list names, start and end dates below. _____	<input type="radio"/> Yes <input type="radio"/> No
<b>2 [Pre-Existing Condition Credit]</b>	
[Does any individual applying for coverage 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 pre-existing condition limitation? If "Yes," you must include a copy of the [creditable coverage document(s) / Certificate of Creditable Coverage]. [You may be subject to a pre-existing condition exclusion until <Coventry> receives these documents.]	<input type="radio"/> Yes <input type="radio"/> No
<b>3 [HIPAA Guarantee Issue Coverage]</b>	
[If you have answered "Yes" to the above Pre-Existing Condition Credit question, you may be HIPAA eligible and may have the right to obtain certain individual health policies on a guaranteed issue basis and without application of any pre-existing condition exclusions or limitations. You must meet the following criteria:	
<ul style="list-style-type: none"> <li>• You must have had coverage for at least 18 months without a break in coverage of 63 days or more;</li> <li>• Your most recent coverage, other than coverage under a short-term health insurance policy, must have been under a group health plan, governmental plan, church plan or other health insurance coverage offered in connection with any such plan;</li> <li>• Your coverage must not have been terminated because of fraud or failure to pay premiums;</li> <li>• You must have exhausted COBRA continuation coverage or continuation under a similar state provision;</li> <li>• You must not be eligible for a group health plan or Medicare and you must not have any other health insurance coverage.</li> </ul>	
<input type="radio"/> Yes, I meet the above criteria and am applying for Guarantee Issue coverage.	
[NOTE: If not all individuals applying for coverage meet the HIPAA requirements, those who are not HIPAA eligible must complete a separate Application for Health Coverage which will be reviewed through the regular underwriting process.]	

**Medical Information** The Medical Details section requires your careful attention to each question. It is important that you answer the questions. Your agent should not answer the questions. If you fail to provide truthful or accurate health history information you may lose your coverage or other penalties may apply. You may want to consult a physician if you have questions regarding the information requested below.

Answer questions on behalf of all individuals applying for coverage. Each individual applying for coverage needs to provide his or her own medical history. Only provide a family member's medical history if the family member is also applying for coverage on this Application. A person applying for coverage does not need to provide any genetic information (including genetic testing, genetic counseling, or genetic education).

Check "Yes" or "No," and provide additional information in the [Medical Details] section when necessary.		
<b>1 Physical Exam</b>		
Has any individual applying for coverage had a physical or wellness exam within the past [6 months / 2 years]? If "Yes," provide details in the [Medical Details] section on page [5].	<input type="radio"/> Yes <input type="radio"/> No	
<b>2 Pregnancy</b>		
Is any individual applying for coverage currently pregnant, expecting a child with anyone, an expectant or surrogate parent, or in the process of adopting a child?	<input type="radio"/> Yes <input type="radio"/> No	
<b>3 Transplants</b>		
Has any individual applying for coverage been a candidate or recipient of an organ or bone marrow transplant? If "Yes," provide details in the [Medical Details] section on page [5].	<input type="radio"/> Yes <input type="radio"/> No	
<b>4 HIV / ARC / AIDS</b>		
Has any individual applying for coverage ever tested positive for Human Immunodeficiency Virus (HIV) or been diagnosed as having AIDS Related Complex / Conditions (ARC), Acquired Immunodeficiency Syndrome (AIDS) or any other medical condition / disorder derived from such infection or immunodeficiency?	<input type="radio"/> Yes <input type="radio"/> No	

Check all that apply. In the past [2/5/10] years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been treated or tested for, been advised to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised that they have or may have had any of the following? If nothing in a category applies, select the "None" box. Provide details for all checked items (including "Other") in the [Medical Details] section on page [5].		
<b>5 Cancer / Cyst / Tumor</b>		
<input type="checkbox"/> Carcinoma, sarcoma, leukemia, lymphoma, myeloma, central nervous system cancers or carcinoma in situ	<input type="checkbox"/> Cyst, growth, lump, mass, tumor or polyp <input type="checkbox"/> Other	<input type="radio"/> None
<b>6 Respiratory System</b>		
<input type="checkbox"/> Allergies or asthma <input type="checkbox"/> Emphysema or chronic lung disease (COPD)	<input type="checkbox"/> Sleep apnea <input type="checkbox"/> Other	<input type="radio"/> None
<b>7 Cardiovascular and Circulatory System</b>		
<input type="checkbox"/> Hypertension or high blood pressure <input type="checkbox"/> Deep Venous Thrombosis or phlebitis <input type="checkbox"/> Varicose veins, blood clot or aneurysm	<input type="checkbox"/> Irregular heartbeat, heart murmur, or mitral valve prolapse <input type="checkbox"/> Heart attack, chest pain or angina <input type="checkbox"/> Other	<input type="radio"/> None
<b>8 Digestive System</b>		
<input type="checkbox"/> Chronic abdominal pain, ulcer, acid reflux or hiatal hernia <input type="checkbox"/> Diverticulitis, diverticulosis, hemorrhoids, or hernia <input type="checkbox"/> Disorder of the esophagus, stomach, colon, rectum, intestine, bowel, gallbladder or pancreas	<input type="checkbox"/> Liver condition or hepatitis A <input type="checkbox"/> Cirrhosis, fatty liver or hepatitis B or C <input type="checkbox"/> Surgical treatment for obesity, gastric bypass or banding <input type="checkbox"/> Other	<input type="radio"/> None
<b>9 Emotional or Mental Health</b>		
<input type="checkbox"/> Anxiety or depression <input type="checkbox"/> Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Obsessive Compulsive Disorder, schizophrenia <input type="checkbox"/> Eating disorder <input type="checkbox"/> Therapy or counseling <input type="checkbox"/> Other	<input type="radio"/> None

<b>10 Muscular or Skeletal System</b>		
<input type="radio"/> Bursitis, tendonitis or gout <input type="radio"/> Disorder of the back, neck or spine <input type="radio"/> Connective tissue disorder, systemic lupus, rheumatoid arthritis <input type="radio"/> Fibromyalgia <input type="radio"/> Disorder of the knee, shoulder, hip or other joint <input type="radio"/> Osteoarthritis, osteoporosis or osteopenia	<input type="radio"/> Temporomandibular joint disorder (TMJ) <input type="radio"/> Fractures or broken bones <input type="radio"/> Prosthetic limbs or devices, or internal fixations (pins, plates, screws) <input type="radio"/> Any chiropractic treatments <input type="radio"/> Other	<input type="radio"/> None
<b>11 Skin</b>		
<input type="radio"/> Acne or rosacea <input type="radio"/> Eczema or psoriasis	<input type="radio"/> Abnormal or cancerous moles, melanoma <input type="radio"/> Other	<input type="radio"/> None
<b>12 Eyes / Ears / Nose / Throat</b>		
<input type="radio"/> Disease or injury of eye <input type="radio"/> Cataracts or glaucoma <input type="radio"/> Ear disorder, ear infections or tubes in ears <input type="radio"/> Hearing loss or cochlear implant	<input type="radio"/> Deviated septum or sinus infection <input type="radio"/> Disorder of the throat, tonsils or adenoids <input type="radio"/> Other	<input type="radio"/> None
<b>13 Kidney or Urinary Tract</b>		
<input type="radio"/> Bladder or urinary tract infection or disorder <input type="radio"/> Kidney infection or disorder	<input type="radio"/> Kidney or bladder stones <input type="radio"/> Other	<input type="radio"/> None
<b>14 Female Reproductive System</b>		
<input type="radio"/> Disorder of the breast or abnormal mammogram <input type="radio"/> Saline breast implants <input type="radio"/> Silicone breast implants <input type="radio"/> Abnormal Pap smear <input type="radio"/> Endometriosis, uterine fibroids or uterine prolapse	<input type="radio"/> Infertility or complications of pregnancy <input type="radio"/> Menopausal disorder <input type="radio"/> Menstrual disorder <input type="radio"/> Cervical, ovarian, uterine or vaginal disorder <input type="radio"/> Other	<input type="radio"/> None
<b>15 Male Reproductive System</b>		
<input type="radio"/> Infertility <input type="radio"/> Penile or testicular disorder	<input type="radio"/> Prostate disorder, elevated PSA, Prostatitis <input type="radio"/> Other	<input type="radio"/> None
<b>16 Sexually Transmitted Diseases</b>		
<input type="radio"/> Chlamydia <input type="radio"/> Genital warts <input type="radio"/> Genital herpes	<input type="radio"/> Human Papilloma Virus (HPV) <input type="radio"/> Gonorrhea or syphilis <input type="radio"/> Other	<input type="radio"/> None
<b>17 Blood / Adrenal / Endocrine / Pituitary / Thyroid</b>		
<input type="radio"/> Anemia <input type="radio"/> Diabetes <input type="radio"/> Elevated blood sugar <input type="radio"/> Elevated cholesterol or triglycerides	<input type="radio"/> Endocrine, adrenal, or pituitary disorder <input type="radio"/> Weight disorder <input type="radio"/> Thyroid disorder <input type="radio"/> Other	<input type="radio"/> None
<b>18 Brain or Nervous System</b>		
<input type="radio"/> Concussion or head injury <input type="radio"/> Migraines or chronic headaches <input type="radio"/> Convulsions, seizures, epilepsy, fainting, tics or tremors	<input type="radio"/> Stroke, Transient Ischemic Attack (TIA) or paralysis <input type="radio"/> Multiple sclerosis <input type="radio"/> Other	<input type="radio"/> None
<b>19 Congenital or Development</b>		
<input type="radio"/> Cleft palate or cleft lip <input type="radio"/> Developmental disorder or delay	<input type="radio"/> Mental retardation, autism, or Down's Syndrome <input type="radio"/> Other	<input type="radio"/> None
<b>20 Alcohol / Drug</b>		
<input type="radio"/> Alcohol abuse, dependency or alcoholism <input type="radio"/> Drug / substance abuse or dependency	<input type="radio"/> A citation or conviction for driving under the influence of alcohol or any drug / substance <input type="radio"/> Other	<input type="radio"/> None
<b>21 Other Conditions</b>		
<p>In the past [2/5/10] years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been treated or tested for, been advised to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised that they have or may have had any other condition(s) not listed on this Application?            If "Yes," provide details in the [Medical Details] Section on page [5].</p>		<input type="radio"/> Yes <input type="radio"/> No

**Medical Details** Please provide COMPLETE details for all questions with a "Yes" answer or a checked box in the [Medical Information] section. Provide the question number you are referencing in the first column. 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.

Q#	Name of Individual Applying for Coverage (Last, First, MI)	Explain Nature of Illness / Condition (include results of any physical exam)	Date of Onset (mm/yy)	Date of Recovery (mm/yy)	Remaining or Ongoing Symptoms or Treatment
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		

**Medications** Please provide COMPLETE details for all medications (prescription or over-the-counter) currently being taken or that have been taken by (including samples), or were prescribed or recommended for, any individual applying for coverage in the past [12 / 24] months. 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.

Name of Individual Applying for Coverage (Last, First, MI)	Date Started (mm/yy)	Date Discontinued (mm/yy)	Medication Name	Dosage and Frequency	Condition / Reason for taking

## Acknowledgements

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

- I understand that all individuals applying for health coverage listed on this Application are subject to medical underwriting review [unless applying for Guarantee Issue coverage]. 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 Coventry's underwriting criteria or terms of coverage.
- I understand that the information that I provide on this Application will be used to determine whether [Coventry] accepts my Application and so provides me with a policy of health coverage for which I'm applying [including Guarantee Issue coverage]. 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 Coventry's sole discretion. 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]. Coventry shall not be financially liable for any health care services rendered prior to the rescission.
- I agree to notify Coventry in writing if I or any individual applying for health coverage receives any new diagnosis, treatment, or health service, or if any of the answers or statements provided on this Application change between the date this Application is signed and the effective date or approval date of coverage, whichever is later. My failure to provide Coventry with this updated health information may result in a denial or rescission of coverage.
- I understand that if any individual applying for coverage is declined for coverage, that individual may not re-apply for CoventryOne coverage for six (6) months from date of signature.
- I understand that this Application is valid for sixty (60) days from the earliest date of signature in the Acknowledgements section.

[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.]

DO NOT cancel your existing insurance coverage until an offer of coverage has been extended by Coventry in writing. Please retain a copy of this application for your records.]

Primary Applicant's Signature	Date	Spouse's Signature (if applying for coverage)	Date
Dependent Signature <sup>1</sup>	Date	Dependent Signature <sup>1</sup>	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<sup>2</sup> 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 <sup>2</sup>	Print Name	Name of child(ren) to whom this applies	Date

<sup>1</sup> Dependent Signature is required for individuals applying for coverage ages 18 and over

<sup>2</sup> 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) <input type="radio"/> Agent <input type="radio"/> Agency <input type="radio"/> General Agent	[Payee Tax ID#]	
[Agent Signature]		Date]

## Premium Payment

**Premium Payment Options** Choose ONE payment option. You must then complete the applicable sections regarding your account information.

[Initial payment by EFT, then:]	[Initial payment by credit card, then:]	[Initial payment by check, then:]
<input type="radio"/> [Monthly EFT [(no administrative fee)]]  <input type="radio"/> [Monthly credit card draw [(subject to Administrative Fee of [\$1-\$10] per person per month)]]  <input type="radio"/> [Monthly billing [(subject to Administrative Fee of [\$1-\$10] per person per month)]]	<input type="radio"/> [Monthly EFT [(subject to [one time] Administrative Fee of [\$1-\$10] per person)]]  <input type="radio"/> [Monthly credit card draw [(subject to Administrative Fee of [\$1-\$10] per person per month)]]  <input type="radio"/> [Monthly billing [(subject to Administrative Fee of [\$1-\$10] per person per month)]]	<input type="radio"/> [Monthly EFT [(subject to [one time] Administrative Fee of [\$5 per person)]]  <input type="radio"/> [Monthly credit card draw [(subject to Administrative Fee of [\$1-\$10] per person per month)]]  <input type="radio"/> [Monthly billing [(subject to Administrative Fee of [\$1-\$10] per person per month)]]

[Payroll Deduction Program This program allows your premium to be deducted directly from your paycheck, post-taxes. Other details apply. To choose this option, you MUST submit a separate <CoventryOne>Payroll Deduction Authorization Form with your Application.]

<input type="radio"/> [NEW Payroll Deduction Program (PDP)]	<input type="radio"/> [EXISTING Payroll Deduction Program (PDP)] PDP number: _____ PDP name: _____
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**EFT (Electronic Funds Transfer) Information** [Complete this section if you have chosen to pay by EFT. When choosing EFT, your monthly premium will be withdrawn automatically from the bank account listed on the [10<sup>th</sup>] day (or the next business day if a weekend/holiday) of the month for which premium is due. If the effective date is anything other than the 1<sup>st</sup> of the month, the initial premium will be prorated based on your effective date.]

<input type="radio"/> Checking Account <input type="radio"/> Savings Account	Name of account holder	9-digit routing number	Account number	
Name of bank / savings institution		Relationship of account holder to Primary Applicant <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Other _____		
Account holder address		City	State	ZIP

**[Credit Card Information** [Complete this section if you have chosen to pay by credit card. If the effective date is anything other than the 1<sup>st</sup> of the month, the initial premium will be prorated based on your effective date.]]

<input type="radio"/> [VISA ] <input type="radio"/> [MasterCard]	[Name of card holder (exactly as on card)]	[Card number]	[Exp. date (mm/yyyy)]	[Verification code <sup>[1]</sup> ]
[Card billing address]		[City]	[State]	[ZIP]

**[Monthly Billing Information** [If you choose Monthly Billing, your bill will be sent to the Mailing Address you supplied in the [Primary Applicant Information] section on page [1]. [At this time, we are unable to bill you at an alternate address.]]

[<sup>1</sup> The Verification Code for your Visa or MasterCard is a 3-digit code printed near the signature strip on the back of your card.]

[Important Note: [[CoventryOne] 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 [your agent] to complete a [CoventryOne Payroll Deduction Authorization Form].]

- By signing this Premium Payment section, you are agreeing to the following statements:
- You understand that it is your responsibility to notify <Plan> at [<insert #>] should your payment information change at any time while you continue to hold a <CoventryOne> policy.
  - You understand that if premium payment is returned unpaid, a fee will be assessed in the amount of [\$20.00]. You authorize <Plan> to collect the premium payment due between the [5<sup>th</sup>] and [15<sup>th</sup>] of the month, including any unpaid fee amount. Failure to remit the first payment rescinds the policy.
  - You understand that providing this payment information does not guarantee approval or coverage.
  - Upon approval and acceptance of this Application, you authorize <PLAN > to initiate automatic withdrawal and / or a billing cycle of applicable premium payments from your provided account or billing information. [Depending on your effective date, your first automatic withdrawal may include up to, but not in excess of, two times your monthly premium amount.]

Account / Card Holder Signature: _____	Date: _____
--	-------------

## Authorization of Release of Information

[I, the Applicant, for myself and any of my Dependents who are under the age of 18 and who 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 <PLAN> 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 <PLAN> to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by <PLAN> for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for <PLAN> 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 <PLAN> 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 <PLAN> to use or disclose the information I provide in this Application (or that the <PLAN> 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 <PLAN> prior to the date such revocation is received by <PLAN>.]

[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*	_____ Date	_____ Dependent Signature*	_____ Date
*Required age 18 and over.			
The below signature must be completed if this is a Child-Only Application.			
_____ Parent/Legal Guardian Signature	_____ Print Name	_____ Relationship to child applying for coverage	_____ Date

SERFF Tracking Number: GHPI-126513145 State: Arkansas  
 Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 44969  
 Company Tracking Number: ARAPP10  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)  
 Product Name: ARAPP10  
 Project Name/Number: /

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> Attached is the Readability (Flesch) Certificate for this filing. <b>Attachment:</b> CHARK 00012-1 Readability Certificate.pdf	Approved-Closed	03/02/2010
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> This filing is the application. <b>Comments:</b>	Approved-Closed	03/02/2010
<b>Bypassed - Item:</b> Health - Actuarial Justification <b>Bypass Reason:</b> As this filing is an application, no actuarial information is attached. Rates will not be affected by this application. <b>Comments:</b>	Approved-Closed	03/02/2010
<b>Bypassed - Item:</b> Outline of Coverage <b>Bypass Reason:</b> No outline of coverage is attached as this is an application, not a document containing benefit information. <b>Comments:</b>	Approved-Closed	03/02/2010
<b>Satisfied - Item:</b> Application-red-line 02/26/10	Approved-Closed	03/02/2010

*SERFF Tracking Number:* GHPI-126513145      *State:* Arkansas  
*Filing Company:* Coventry Health and Life Insurance Company      *State Tracking Number:* 44969  
*Company Tracking Number:* ARAPP10  
*TOI:* H16I Individual Health - Major Medical      *Sub-TOI:* H16I.005A Individual - Preferred Provider  
(PPO)  
  
*Product Name:* ARAPP10  
*Project Name/Number:* /

**Comments:**

Attached is the red-line version of this document showing the changes as per the objection letter dated 2/24/10.

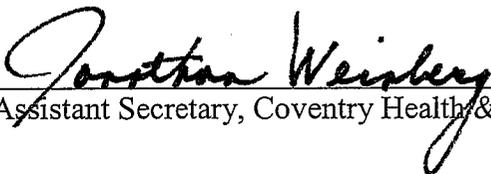
**Attachment:**

CHARK 00012-1-rev #1-red.pdf

**READABILITY CERTIFICATION**

I hereby certify that the following forms comply with the Arkansas minimum Flesch reading ease test scores pursuant to A.C.A. § 23-80-206:

CHARK 00012-1

  
\_\_\_\_\_  
(Signature) Assistant Secretary, Coventry Health & Life Insurance Company

Jonathan D. Weinberg

\_\_\_\_\_  
(Print Name)

February 22, 2010

\_\_\_\_\_  
(Date)



## 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.

Full Name (Last, First, MI)	Social Security Number <sup>[1]</sup>	Birthdate (mm/dd/yyyy)	Gender (M or F)	Height (ft. in.)	Weight (lbs.)	Tobacco use in past 12 months? <sup>[2]</sup>	U.S. residency for past [6 months / 2 years]? <sup>[3]</sup>
1 Primary Applicant (blank if Child-Only)						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2 Spouse (blank if Child-Only)						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
3 Dependent Child or Child-Only						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
4 Additional Child						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
5 Additional Child						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
6 Additional Child						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							

[<sup>1</sup>Not required in <State>]. [<sup>2</sup> 'Tobacco use' constitutes use of tobacco or tobacco cessation products in the past twelve (12) months. <sup>3</sup> 'U.S. residency' refers to the designated individual living [legally] in the United States for the past [6 months/2 years].

<b>1 Prior Insurance Coverage</b>	
Has any individual applying for coverage had any health insurance coverage in the past 2 years? If "Yes," list names, start and end dates below. _____	<input type="radio"/> Yes <input type="radio"/> No
<b>2 [Pre-Existing Condition Credit]</b>	
[Does any individual applying for coverage 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 pre-existing condition limitation? If "Yes," you must include a copy of the [creditable coverage document(s) / Certificate of Creditable Coverage]. [You may be subject to a pre-existing condition exclusion until <Coventry> receives these documents.]	<input type="radio"/> Yes <input type="radio"/> No
<b>3 [HIPAA Guarantee Issue Coverage]</b>	
[If you have answered "Yes" to the above Pre-Existing Condition Credit question, you may be HIPAA eligible and may have the right to obtain certain individual health policies on a guaranteed issue basis and without application of any pre-existing condition exclusions or limitations. You must meet the following criteria:	
<ul style="list-style-type: none"> <li>• You must have had coverage for at least 18 months without a break in coverage of 63 days or more;</li> <li>• Your most recent coverage, other than coverage under a short-term health insurance policy, must have been under a group health plan, governmental plan, church plan or other health insurance coverage offered in connection with any such plan;</li> <li>• Your coverage must not have been terminated because of fraud or failure to pay premiums;</li> <li>• You must have exhausted COBRA continuation coverage or continuation under a similar state provision;</li> <li>• You must not be eligible for a group health plan or Medicare and you must not have any other health insurance coverage.</li> </ul>	
<input type="radio"/> Yes, I meet the above criteria and am applying for Guarantee Issue coverage.	
[NOTE: If not all individuals applying for coverage meet the HIPAA requirements, those who are not HIPAA eligible must complete a separate Application for Health Coverage which will be reviewed through the regular underwriting process.]	

**Medical Information** The Medical Details section requires your careful attention to each question. It is important that you answer the questions. Your agent should not answer the questions. If you fail to provide truthful or accurate health history information you may lose your coverage or other penalties may apply. You may want to consult a physician if you have questions regarding the information requested below.

Answer questions on behalf of all individuals applying for coverage. Each individual applying for coverage needs to provide his or her own medical history. Only provide a family member's medical history if the family member is also applying for coverage on this Application. A person applying for coverage does not need to provide any genetic information (including genetic testing, genetic counseling, or genetic education).

Check "Yes" or "No," and provide additional information in the [Medical Details] section when necessary.	
<b>1 Physical Exam</b>	
Has any individual applying for coverage had a physical or wellness exam within the past [6 months / 2 years]? If "Yes," provide details in the [Medical Details] section on page [5].	<input type="radio"/> Yes <input type="radio"/> No
<b>2 Pregnancy</b>	
Is any individual applying for coverage currently pregnant, expecting a child with anyone, an expectant or surrogate parent, or in the process of adopting a child?	<input type="radio"/> Yes <input type="radio"/> No
<b>3 Transplants</b>	
Has any individual applying for coverage been a candidate or recipient of an organ or bone marrow transplant? If "Yes," provide details in the [Medical Details] section on page [5].	<input type="radio"/> Yes <input type="radio"/> No
<b>4 HIV / ARC / AIDS</b>	
Has any individual applying for coverage ever tested positive for Human Immunodeficiency Virus (HIV) or been diagnosed as having AIDS Related Complex / Conditions (ARC), Acquired Immunodeficiency Syndrome (AIDS) or any other medical condition / disorder derived from such infection or immunodeficiency?	<input type="radio"/> Yes <input type="radio"/> No

Check all that apply. In the past [2/5/10] years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been treated or tested for, been advised to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised that they have or may have had any of the following? If nothing in a category applies, select the "None" box. Provide details for all checked items (including "Other") in the [Medical Details] section on page [5].	
<b>5 Cancer / Cyst / Tumor</b>	
<input type="radio"/> Carcinoma, sarcoma, leukemia, lymphoma, myeloma, central nervous system cancers or carcinoma in situ <input type="radio"/> Cyst, growth, lump, mass, tumor or polyp <input type="radio"/> Other	<input type="radio"/> None
<b>6 Respiratory System</b>	
<input type="radio"/> Allergies or asthma <input type="radio"/> Emphysema or chronic lung disease (COPD)	<input type="radio"/> Sleep apnea <input type="radio"/> Other <input type="radio"/> None
<b>7 Cardiovascular and Circulatory System</b>	
<input type="radio"/> Hypertension or high blood pressure <input type="radio"/> Deep Venous Thrombosis or phlebitis <input type="radio"/> Varicose veins, blood clot or aneurysm	<input type="radio"/> Irregular heartbeat, heart murmur, or mitral valve prolapse <input type="radio"/> Heart attack, chest pain or angina <input type="radio"/> Other <input type="radio"/> None
<b>8 Digestive System</b>	
<input type="radio"/> Chronic abdominal pain, ulcer, acid reflux or hiatal hernia <input type="radio"/> Diverticulitis, diverticulosis, hemorrhoids, or hernia <input type="radio"/> Disorder of the esophagus, stomach, colon, rectum, intestine, bowel, gallbladder or pancreas	<input type="radio"/> Liver condition or hepatitis A <input type="radio"/> Cirrhosis, fatty liver or hepatitis B or C <input type="radio"/> Surgical treatment for obesity, gastric bypass or banding <input type="radio"/> Other <input type="radio"/> None
<b>9 Emotional or Mental Health</b>	
<input type="radio"/> Anxiety or depression <input type="radio"/> Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder <input type="radio"/> Bipolar disorder	<input type="radio"/> Obsessive Compulsive Disorder, schizophrenia <input type="radio"/> Eating disorder <input type="radio"/> Therapy or counseling <input type="radio"/> Other <input type="radio"/> None

<b>10 Muscular or Skeletal System</b>		
<input type="radio"/> Bursitis, tendonitis or gout <input type="radio"/> Disorder of the back, neck or spine <input type="radio"/> Connective tissue disorder, systemic lupus, rheumatoid arthritis <input type="radio"/> Fibromyalgia <input type="radio"/> Disorder of the knee, shoulder, hip or other joint <input type="radio"/> Osteoarthritis, osteoporosis or osteopenia	<input type="radio"/> Temporomandibular joint disorder (TMJ) <input type="radio"/> Fractures or broken bones <input type="radio"/> Prosthetic limbs or devices, or internal fixations (pins, plates, screws) <input type="radio"/> Any chiropractic treatments <input type="radio"/> Other	<input type="radio"/> None
<b>11 Skin</b>		
<input type="radio"/> Acne or rosacea <input type="radio"/> Eczema or psoriasis	<input type="radio"/> Abnormal or cancerous moles, melanoma <input type="radio"/> Other	<input type="radio"/> None
<b>12 Eyes / Ears / Nose / Throat</b>		
<input type="radio"/> Disease or injury of eye <input type="radio"/> Cataracts or glaucoma <input type="radio"/> Ear disorder, ear infections or tubes in ears <input type="radio"/> Hearing loss or cochlear implant	<input type="radio"/> Deviated septum or sinus infection <input type="radio"/> Disorder of the throat, tonsils or adenoids <input type="radio"/> Other	<input type="radio"/> None
<b>13 Kidney or Urinary Tract</b>		
<input type="radio"/> Bladder or urinary tract infection or disorder <input type="radio"/> Kidney infection or disorder	<input type="radio"/> Kidney or bladder stones <input type="radio"/> Other	<input type="radio"/> None
<b>14 Female Reproductive System</b>		
<input type="radio"/> Disorder of the breast or abnormal mammogram <input type="radio"/> Saline breast implants <input type="radio"/> Silicone breast implants <input type="radio"/> Abnormal Pap smear <input type="radio"/> Endometriosis, uterine fibroids or uterine prolapse	<input type="radio"/> Infertility or complications of pregnancy <input type="radio"/> Menopausal disorder <input type="radio"/> Menstrual disorder <input type="radio"/> Cervical, ovarian, uterine or vaginal disorder <input type="radio"/> Other	<input type="radio"/> None
<b>15 Male Reproductive System</b>		
<input type="radio"/> Infertility <input type="radio"/> Penile or testicular disorder	<input type="radio"/> Prostate disorder, elevated PSA, Prostatitis <input type="radio"/> Other	<input type="radio"/> None
<b>16 Sexually Transmitted Diseases</b>		
<input type="radio"/> Chlamydia <input type="radio"/> Genital warts <input type="radio"/> Genital herpes	<input type="radio"/> Human Papilloma Virus (HPV) <input type="radio"/> Gonorrhea or syphilis <input type="radio"/> Other	<input type="radio"/> None
<b>17 Blood / Adrenal / Endocrine / Pituitary / Thyroid</b>		
<input type="radio"/> Anemia <input type="radio"/> Diabetes <input type="radio"/> Elevated blood sugar <input type="radio"/> Elevated cholesterol or triglycerides	<input type="radio"/> Endocrine, adrenal, or pituitary disorder <input type="radio"/> Weight disorder <input type="radio"/> Thyroid disorder <input type="radio"/> Other	<input type="radio"/> None
<b>18 Brain or Nervous System</b>		
<input type="radio"/> Concussion or head injury <input type="radio"/> Migraines or chronic headaches <input type="radio"/> Convulsions, seizures, epilepsy, fainting, tics or tremors	<input type="radio"/> Stroke, Transient Ischemic Attack (TIA) or paralysis <input type="radio"/> Multiple sclerosis <input type="radio"/> Other	<input type="radio"/> None
<b>19 Congenital or Development</b>		
<input type="radio"/> Cleft palate or cleft lip <input type="radio"/> Developmental disorder or delay	<input type="radio"/> Mental retardation, autism, or Down's Syndrome <input type="radio"/> Other	<input type="radio"/> None
<b>20 Alcohol / Drug</b>		
<input type="radio"/> Alcohol abuse, dependency or alcoholism <input type="radio"/> Drug / substance abuse or dependency	<input type="radio"/> A citation or conviction for driving under the influence of alcohol or any drug / substance <input type="radio"/> Other	<input type="radio"/> None
<b>21 Other Conditions</b>		
<p>In the past [2/5/10] years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been treated or tested for, been advised to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised that they have or may have had any other condition(s) not listed on this Application?            If "Yes," provide details in the [Medical Details] Section on page [5].</p>		<input type="radio"/> Yes <input type="radio"/> No

**Medical Details** Please provide COMPLETE details for all questions with a "Yes" answer or a checked box in the [Medical Information] section. Provide the question number you are referencing in the first column. 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.

Q#	Name of Individual Applying for Coverage (Last, First, MI)	Explain Nature of Illness / Condition (include results of any physical exam)	Date of Onset (mm/yy)	Date of Recovery (mm/yy)	Remaining or Ongoing Symptoms or Treatment
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		

**Medications** Please provide COMPLETE details for all medications (prescription or over-the-counter) currently being taken or that have been taken by (including samples), or were prescribed or recommended for, any individual applying for coverage in the past [12 / 24] months. 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.

Name of Individual Applying for Coverage (Last, First, MI)	Date Started (mm/yy)	Date Discontinued (mm/yy)	Medication Name	Dosage and Frequency	Condition / Reason for taking

## Acknowledgements

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

- I understand that all individuals applying for health coverage listed on this Application are subject to medical underwriting review [unless applying for Guarantee Issue coverage]. 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 Coventry's underwriting criteria or terms of coverage.
- I understand that the information that I provide on this Application will be used to determine whether [Coventry] accepts my Application and so provides me with a policy of health coverage for which I'm applying [including Guarantee Issue coverage]. 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 Coventry's sole discretion. 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]. Coventry shall not be financially liable for any health care services rendered prior to the rescission.
- I agree to notify Coventry in writing if I or any individual applying for health coverage receives any new diagnosis, treatment, or health service, or if any of the answers or statements provided on this Application change between the date this Application is signed and the effective date or approval date of coverage, whichever is later. My failure to provide Coventry with this updated health information may result in a denial or rescission of coverage.
- I understand that if any individual applying for coverage is declined for coverage, that individual may not re-apply for CoventryOne coverage for six (6) months from date of signature.
- I understand that this Application is valid for sixty (60) days from the earliest date of signature in the Acknowledgements section.

[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.]

DO NOT cancel your existing insurance coverage until an offer of coverage has been extended by Coventry in writing. Please retain a copy of this application for your records.]

Primary Applicant's Signature	Date	Spouse's Signature (if applying for coverage)	Date
Dependent Signature <sup>1</sup>	Date	Dependent Signature <sup>1</sup>	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<sup>2</sup> 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 <sup>2</sup>	Print Name	Name of child(ren) to whom this applies	Date

<sup>1</sup> Dependent Signature is required for individuals applying for coverage ages 18 and over

<sup>2</sup> 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) <input type="radio"/> Agent <input type="radio"/> Agency <input type="radio"/> General Agent	[Payee Tax ID#]	
[Agent Signature]		Date]

## Premium Payment

**Premium Payment Options** Choose ONE payment option. You must then complete the applicable sections regarding your account information.

<b>[Initial payment by EFT, then:]</b>	<b>[Initial payment by credit card, then:]</b>	<b>[Initial payment by check, then:]</b>
<input type="radio"/> [Monthly EFT [(no administrative fee)]]  <input type="radio"/> [Monthly credit card draw [(subject to Administrative Fee of [\$1-\$10] per person per month)]]  <input type="radio"/> [Monthly billing [(subject to Administrative Fee of [\$1-\$10] per person per month)]]	<input type="radio"/> [Monthly EFT [(subject to [one time] Administrative Fee of [\$1-\$10] per person)]]  <input type="radio"/> [Monthly credit card draw [(subject to Administrative Fee of [\$1-\$10] per person per month)]]  <input type="radio"/> [Monthly billing [(subject to Administrative Fee of [\$1-\$10] per person per month)]]	<input type="radio"/> [Monthly EFT [(subject to [one time] Administrative Fee of [\$5 per person)]]  <input type="radio"/> [Monthly credit card draw [(subject to Administrative Fee of [\$1-\$10] per person per month)]]  <input type="radio"/> [Monthly billing [(subject to Administrative Fee of [\$1-\$10] per person per month)]]

**[Payroll Deduction Program** This program allows your premium to be deducted directly from your paycheck, post-taxes. Other details apply. To choose this option, you MUST submit a separate <CoventryOne>Payroll Deduction Authorization Form with your Application.]

<input type="radio"/> [NEW Payroll Deduction Program (PDP)]	<input type="radio"/> [EXISTING Payroll Deduction Program (PDP) PDP number: _____ PDP name: _____ ]
---	--

**EFT (Electronic Funds Transfer) Information** [Complete this section if you have chosen to pay by EFT. When choosing EFT, your monthly premium will be withdrawn automatically from the bank account listed on the [10<sup>th</sup>] day (or the next business day if a weekend/holiday) of the month for which premium is due. If the effective date is anything other than the 1<sup>st</sup> of the month, the initial premium will be prorated based on your effective date.]

<input type="radio"/> Checking Account <input type="radio"/> Savings Account	Name of account holder	9-digit routing number	Account number										
		<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>											
Name of bank / savings institution		Relationship of account holder to Primary Applicant <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Other _____											
Account holder address		City	State	ZIP									

**[Credit Card Information** [Complete this section if you have chosen to pay by credit card. If the effective date is anything other than the 1<sup>st</sup> of the month, the initial premium will be prorated based on your effective date.]]

<input type="radio"/> [VISA ] <input type="radio"/> [MasterCard]	[Name of card holder (exactly as on card)]	[Card number]	[Exp. date (mm/yyyy)]	[Verification code <sup>[1]</sup> ]
[Card billing address]		[City]	[State]	[ZIP]

**[Monthly Billing Information** [If you choose Monthly Billing, your bill will be sent to the Mailing Address you supplied in the [Primary Applicant Information] section on page [1]. [At this time, we are unable to bill you at an alternate address.]]

[<sup>1</sup> The Verification Code for your Visa or MasterCard is a 3-digit code printed near the signature strip on the back of your card.]

**[Important Note:** [[CoventryOne] 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 [your agent] to complete a [CoventryOne Payroll Deduction Authorization Form].]

- By signing this Premium Payment section, you are agreeing to the following statements:
- You understand that it is your responsibility to notify <Plan> at [<insert #>] should your payment information change at any time while you continue to hold a <CoventryOne> policy.
  - You understand that if premium payment is returned unpaid, a fee will be assessed in the amount of [\$20.00]. You authorize <Plan> to collect the premium payment due between the [5<sup>th</sup>] and [15<sup>th</sup>] of the month, including any unpaid fee amount. Failure to remit the first payment rescinds the policy.
  - You understand that providing this payment information does not guarantee approval or coverage.
  - Upon approval and acceptance of this Application, you authorize <PLAN > to initiate automatic withdrawal and / or a billing cycle of applicable premium payments from your provided account or billing information. [Depending on your effective date, your first automatic withdrawal may include up to, but not in excess of, two times your monthly premium amount.]

Account / Card Holder Signature: _____	Date: _____
--	-------------

## Authorization of Release of Information

[I, the Applicant, for myself and any of my Dependents who are under the age of 18 and who 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 <PLAN> 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 <PLAN> to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by <PLAN> for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for <PLAN> 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 <PLAN> 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 <PLAN> to use or disclose the information I provide in this Application (or that the <PLAN> 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 <PLAN> prior to the date such revocation is received by <PLAN>.]

[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*	_____ Date	_____ Dependent Signature*	_____ Date
*Required age 18 and over.			
The below signature must be completed if this is a Child-Only Application.			
_____ Parent/Legal Guardian Signature	_____ Print Name	_____ Relationship to child applying for coverage	_____ Date

SERFF Tracking Number: GHPI-126513145 State: Arkansas  
 Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 44969  
 Company Tracking Number: ARAPP10  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)  
 Product Name: ARAPP10  
 Project Name/Number: /

## 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)
02/23/2010	Form	Application for Health Coverage	02/26/2010	CHARK 00012-1.pdf (Superseded)

[CoventryOne]  
Received Date: \_\_\_\_\_

[Health Plan Name] [Special State or Association Name]

## 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.

[Submit completed Application for Health Coverage to:  
<Plan> address/fax]

Check all that apply:

- New Application  Add a Dependent  Guarantee Issue  Plan Benefits Increase  Child-Only Application (under 18 years old)

**[Plan Choice]** Choose one (1) plan only. [If other individuals applying for coverage wish to apply for different plans, a separate Application must be used.]

<p>[Plan Category]</p> <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name]	<p>[Plan Category]</p> <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name]	<p>[Plan Category]</p> <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Other plan name]	<p>[QHDHP Plans]</p> <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name]
---	---	---	---

[Maternity benefits for this plan begin twelve (12) months from the effective date of the policy.]  
 [If you have selected a <CoventryOne> Qualified High-Deductible Health Plan (QHDHP), you are eligible to open a Health Savings Account (HSA) through our HSA trustee, [Health Equity], upon approval. [Through [HealthEquity], [you will be subject to an account activation fee of [\$1 - \$30] and [monthly account maintenance fees of [\$1 - \$10] may apply]].  
 I elect to have an HSA opened through [HealthEquity]

[Optional Rider[s] The below rider[s] [is/are] optional. Please note that additional premium may apply.]  
 [TMJ Treatment – Applicant elects to provide coverage for Medically Necessary treatment related to musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD). (AR Code 23-79-150). Additional premium may apply.]

Requested Effective Date:  Day of <CoventryOne> Approval OR  \_\_\_ / \_\_\_ / 20 \_\_\_ OR  [[1<sup>st</sup> or 15<sup>th</sup>] day of \_\_\_\_\_ 20 \_\_\_\_]  
 Requested Effective Date must be after, but no MORE than sixty days past the signature date of the Application. Requested Effective Date is not guaranteed.  
 Amount quoted for Requested Effective Date: \$\_\_\_\_\_ / Month  Individual  Family  
 [Note: The amount quoted is an estimated cost of the selected health plan, which is subject to change based on medical history, the underwriting process, and, if any, other relevant factors.]

### 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	Primary phone number ( ) -
Home address	City	State	ZIP	County	
Mailing address (if different from address above)	City	State	ZIP	Best time and phone number to receive a call regarding this Application, if necessary: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Anytime (8am-8pm) ( ) -	
E-mail address (if we may correspond with you via E-mail)	<input type="checkbox"/> [Check here to consent to receiving your [policy] and other pertinent documents by email only]				
Relationship (if Child-Only Application)	[Occupation / Title]				

## 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.

Full Name (Last, First, MI)	Social Security Number <sup>[1]</sup>	Birthdate (mm/dd/yyyy)	Gender (M or F)	Height (ft. in.)	Weight (lbs.)	Tobacco use in past 12 months? <sup>[2]</sup>	U.S. residency for past [6 months / 2 years]? <sup>[3]</sup>
1 Primary Applicant (blank if Child-Only)						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2 Spouse (blank if Child-Only)						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
3 Dependent Child or Child-Only						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
4 Additional Child						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
5 Additional Child						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
6 Additional Child						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							

[<sup>1</sup>Not required in <State>]. [<sup>2</sup> 'Tobacco use' constitutes use of tobacco or tobacco cessation products in the past twelve (12) months. <sup>3</sup> 'U.S. residency' refers to the designated individual living [legally] in the United States for the past [6 months/2 years].

<b>1 Prior Insurance Coverage</b>	
Has any individual applying for coverage had any health insurance coverage in the past 2 years? If "Yes," list names, start and end dates below. _____	<input type="radio"/> Yes <input type="radio"/> No
<b>2 [Pre-Existing Condition Credit]</b>	
[Does any individual applying for coverage 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 pre-existing condition limitation? If "Yes," you must include a copy of the [creditable coverage document(s) / Certificate of Creditable Coverage]. [You may be subject to a pre-existing condition exclusion until <Coventry> receives these documents.] ]	<input type="radio"/> Yes <input type="radio"/> No
<b>3 [HIPAA Guarantee Issue Coverage]</b>	
[If you have answered "Yes" to the above Pre-Existing Condition Credit question, you may be HIPAA eligible and may have the right to obtain certain individual health policies on a guaranteed issue basis and without application of any pre-existing condition exclusions or limitations. You must meet the following criteria:	
<ul style="list-style-type: none"> <li>• You must have had coverage for at least 18 months without a break in coverage of 63 days or more;</li> <li>• Your most recent coverage, other than coverage under a short-term health insurance policy, must have been under a group health plan, governmental plan, church plan or other health insurance coverage offered in connection with any such plan;</li> <li>• Your coverage must not have been terminated because of fraud or failure to pay premiums;</li> <li>• You must have exhausted COBRA continuation coverage or continuation under a similar state provision;</li> <li>• You must not be eligible for a group health plan or Medicare and you must not have any other health insurance coverage.</li> </ul>	
<input type="radio"/> Yes, I meet the above criteria and am applying for Guarantee Issue coverage.	
[NOTE: If not all individuals applying for coverage meet the HIPAA requirements, those who are not HIPAA eligible must complete a separate Application for Health Coverage which will be reviewed through the regular underwriting process.]	

**Medical Information** The Medical Details section requires your careful attention to each question. It is important that you answer the questions. Your agent should not answer the questions. If you fail to provide truthful or accurate health history information you may lose your coverage or other penalties may apply. You may want to consult a physician if you have questions regarding the information requested below.

Answer questions on behalf of all individuals applying for coverage. Each individual applying for coverage needs to provide his or her own medical history. Only provide a family member's medical history if the family member is also applying for coverage on this Application. A person applying for coverage does not need to provide any genetic information (including genetic testing, genetic counseling, or genetic education).

Check "Yes" or "No," and provide additional information in the [Medical Details] section when necessary.		
<b>1 Physical Exam</b>		
Has any individual applying for coverage had a physical or wellness exam within the past [6 months / 2 years]? If "Yes," provide details in the [Medical Details] section on page [5].	<input type="radio"/> Yes <input type="radio"/> No	
<b>2 Pregnancy</b>		
Is any individual applying for coverage currently pregnant, expecting a child with anyone, an expectant or surrogate parent, or in the process of adopting a child?	<input type="radio"/> Yes <input type="radio"/> No	
<b>3 Transplants</b>		
Has any individual applying for coverage been a candidate or recipient of an organ or bone marrow transplant? If "Yes," provide details in the [Medical Details] section on page [5].	<input type="radio"/> Yes <input type="radio"/> No	
<b>4 HIV / ARC / AIDS</b>		
Has any individual applying for coverage ever tested positive for Human Immunodeficiency Virus (HIV) or been diagnosed as having AIDS Related Complex / Conditions (ARC), Acquired Immunodeficiency Syndrome (AIDS) or any other medical condition / disorder derived from such infection or immunodeficiency?	<input type="radio"/> Yes <input type="radio"/> No	

Check all that apply. In the past [2/5/10] years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been treated or tested for, been advised to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised that they have or may have had any of the following? If nothing in a category applies, select the "None" box. Provide details for all checked items (including "Other") in the [Medical Details] section on page [5].		
<b>5 Cancer / Cyst / Tumor</b>		
<input type="radio"/> Carcinoma, sarcoma, leukemia, lymphoma, myeloma, central nervous system cancers or carcinoma in situ <input type="radio"/> Cyst, growth, lump, mass, tumor or polyp <input type="radio"/> Other	<input type="radio"/> None	
<b>6 Respiratory System</b>		
<input type="radio"/> Allergies or asthma <input type="radio"/> Emphysema or chronic lung disease (COPD)	<input type="radio"/> Sleep apnea <input type="radio"/> Other	<input type="radio"/> None
<b>7 Cardiovascular and Circulatory System</b>		
<input type="radio"/> Hypertension or high blood pressure <input type="radio"/> Deep Venous Thrombosis or phlebitis <input type="radio"/> Varicose veins, blood clot or aneurysm	<input type="radio"/> Irregular heartbeat, heart murmur, or mitral valve prolapse <input type="radio"/> Heart attack, chest pain or angina <input type="radio"/> Other	<input type="radio"/> None
<b>8 Digestive System</b>		
<input type="radio"/> Chronic abdominal pain, ulcer, acid reflux or hiatal hernia <input type="radio"/> Diverticulitis, diverticulosis, hemorrhoids, or hernia <input type="radio"/> Disorder of the esophagus, stomach, colon, rectum, intestine, bowel, gallbladder or pancreas	<input type="radio"/> Liver condition or hepatitis A <input type="radio"/> Cirrhosis, fatty liver or hepatitis B or C <input type="radio"/> Surgical treatment for obesity, gastric bypass or banding <input type="radio"/> Other	<input type="radio"/> None
<b>9 Emotional or Mental Health</b>		
<input type="radio"/> Anxiety or depression <input type="radio"/> Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder <input type="radio"/> Bipolar disorder	<input type="radio"/> Obsessive Compulsive Disorder, schizophrenia <input type="radio"/> Eating disorder <input type="radio"/> Therapy or counseling <input type="radio"/> Other	<input type="radio"/> None

<b>10 Muscular or Skeletal System</b>		
<input type="radio"/> Bursitis, tendonitis or gout <input type="radio"/> Disorder of the back, neck or spine <input type="radio"/> Connective tissue disorder, systemic lupus, rheumatoid arthritis <input type="radio"/> Fibromyalgia <input type="radio"/> Disorder of the knee, shoulder, hip or other joint <input type="radio"/> Osteoarthritis, osteoporosis or osteopenia	<input type="radio"/> Temporomandibular joint disorder (TMJ) <input type="radio"/> Fractures or broken bones <input type="radio"/> Prosthetic limbs or devices, or internal fixations (pins, plates, screws) <input type="radio"/> Any chiropractic treatments <input type="radio"/> Other	<input type="radio"/> None
<b>11 Skin</b>		
<input type="radio"/> Acne or rosacea <input type="radio"/> Eczema or psoriasis	<input type="radio"/> Abnormal or cancerous moles, melanoma <input type="radio"/> Other	<input type="radio"/> None
<b>12 Eyes / Ears / Nose / Throat</b>		
<input type="radio"/> Disease or injury of eye <input type="radio"/> Cataracts or glaucoma <input type="radio"/> Ear disorder, ear infections or tubes in ears <input type="radio"/> Hearing loss or cochlear implant	<input type="radio"/> Deviated septum or sinus infection <input type="radio"/> Disorder of the throat, tonsils or adenoids <input type="radio"/> Other	<input type="radio"/> None
<b>13 Kidney or Urinary Tract</b>		
<input type="radio"/> Bladder or urinary tract infection or disorder <input type="radio"/> Kidney infection or disorder	<input type="radio"/> Kidney or bladder stones <input type="radio"/> Other	<input type="radio"/> None
<b>14 Female Reproductive System</b>		
<input type="radio"/> Disorder of the breast or abnormal mammogram <input type="radio"/> Saline breast implants <input type="radio"/> Silicone breast implants <input type="radio"/> Abnormal Pap smear <input type="radio"/> Endometriosis, uterine fibroids or uterine prolapse	<input type="radio"/> Infertility or complications of pregnancy <input type="radio"/> Menopausal disorder <input type="radio"/> Menstrual disorder <input type="radio"/> Cervical, ovarian, uterine or vaginal disorder <input type="radio"/> Other	<input type="radio"/> None
<b>15 Male Reproductive System</b>		
<input type="radio"/> Infertility <input type="radio"/> Penile or testicular disorder	<input type="radio"/> Prostate disorder, elevated PSA, Prostatitis <input type="radio"/> Other	<input type="radio"/> None
<b>16 Sexually Transmitted Diseases</b>		
<input type="radio"/> Chlamydia <input type="radio"/> Genital warts <input type="radio"/> Genital herpes	<input type="radio"/> Human Papilloma Virus (HPV) <input type="radio"/> Gonorrhea or syphilis <input type="radio"/> Other	<input type="radio"/> None
<b>17 Blood / Adrenal / Endocrine / Pituitary / Thyroid</b>		
<input type="radio"/> Anemia <input type="radio"/> Diabetes <input type="radio"/> Elevated blood sugar <input type="radio"/> Elevated cholesterol or triglycerides	<input type="radio"/> Endocrine, adrenal, or pituitary disorder <input type="radio"/> Weight disorder <input type="radio"/> Thyroid disorder <input type="radio"/> Other	<input type="radio"/> None
<b>18 Brain or Nervous System</b>		
<input type="radio"/> Concussion or head injury <input type="radio"/> Migraines or chronic headaches <input type="radio"/> Convulsions, seizures, epilepsy, fainting, tics or tremors	<input type="radio"/> Stroke, Transient Ischemic Attack (TIA) or paralysis <input type="radio"/> Multiple sclerosis <input type="radio"/> Other	<input type="radio"/> None
<b>19 Congenital or Development</b>		
<input type="radio"/> Cleft palate or cleft lip <input type="radio"/> Developmental disorder or delay	<input type="radio"/> Mental retardation, autism, or Down's Syndrome <input type="radio"/> Other	<input type="radio"/> None
<b>20 Alcohol / Drug</b>		
<input type="radio"/> Alcohol abuse, dependency or alcoholism <input type="radio"/> Drug / substance abuse or dependency	<input type="radio"/> A citation or conviction for driving under the influence of alcohol or any drug / substance <input type="radio"/> Other	<input type="radio"/> None
<b>21 Other Conditions</b>		
<p>In the past [2/5/10] years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been treated or tested for, been advised to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised that they have or may have had any other condition(s) not listed on this Application?            If "Yes," provide details in the [Medical Details] Section on page [5].</p>		<input type="radio"/> Yes <input type="radio"/> No

**Medical Details** Please provide COMPLETE details for all questions with a "Yes" answer or a checked box in the [Medical Information] section. Provide the question number you are referencing in the first column. 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.

Q#	Name of Individual Applying for Coverage (Last, First, MI)	Explain Nature of Illness / Condition (include results of any physical exam)	Date of Onset (mm/yy)	Date of Recovery (mm/yy)	Remaining or Ongoing Symptoms or Treatment
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		

**Medications** Please provide COMPLETE details for all medications (prescription or over-the-counter) currently being taken or that have been taken by (including samples), or were prescribed or recommended for, any individual applying for coverage in the past [12 / 24] months. 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.

Name of Individual Applying for Coverage (Last, First, MI)	Date Started (mm/yy)	Date Discontinued (mm/yy)	Medication Name	Dosage and Frequency	Condition / Reason for taking

## Acknowledgements

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

- I understand that all individuals applying for health coverage listed on this Application are subject to medical underwriting review [unless applying for Guarantee Issue coverage]. 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 Coventry's underwriting criteria or terms of coverage.
- I understand that the information that I provide on this Application will be used to determine whether [Coventry] accepts my Application and so provides me with a policy of health coverage for which I'm applying [including Guarantee Issue coverage]. 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 Coventry's sole discretion. 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]. Coventry shall not be financially liable for any health care services rendered prior to the rescission.
- I agree to notify Coventry in writing if I or any individual applying for health coverage receives any new diagnosis, treatment, or health service, or if any of the answers or statements provided on this Application change between the date this Application is signed and the effective date or approval date of coverage, whichever is later. My failure to provide Coventry with this updated health information may result in a denial or rescission of coverage.
- I understand that if any individual applying for coverage is declined for coverage, that individual may not re-apply for CoventryOne coverage for six (6) months from date of signature.
- I understand that this Application is valid for sixty (60) days from the earliest date of signature in the Acknowledgements section.

[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.]

DO NOT cancel your existing insurance coverage until an offer of coverage has been extended by Coventry in writing. Please retain a copy of this application for your records.]

Primary Applicant's Signature	Date	Spouse's Signature (if applying for coverage)	Date
Dependent Signature <sup>1</sup>	Date	Dependent Signature <sup>1</sup>	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<sup>2</sup> 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 <sup>2</sup>	Print Name	Name of child(ren) to whom this applies	Date

<sup>1</sup> Dependent Signature is required for individuals applying for coverage ages 18 and over

<sup>2</sup> 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) <input type="radio"/> Agent <input type="radio"/> Agency <input type="radio"/> General Agent	[Payee Tax ID#]	
[Agent Signature]		Date]

## Premium Payment

**Premium Payment Options** Choose ONE payment option. You must then complete the applicable sections regarding your account information.

[Initial payment by EFT, then:]	[Initial payment by credit card, then:]	[Initial payment by check, then:]
<input type="radio"/> [Monthly EFT [(no administrative fee)]]  <input type="radio"/> [Monthly credit card draw [(subject to Administrative Fee of [\$1-\$10] per person per month)]]  <input type="radio"/> [Monthly billing [(subject to Administrative Fee of [\$1-\$10] per person per month)]]	<input type="radio"/> [Monthly EFT [(subject to [one time] Administrative Fee of [\$1-\$10] per person)]]  <input type="radio"/> [Monthly credit card draw [(subject to Administrative Fee of [\$1-\$10] per person per month)]]  <input type="radio"/> [Monthly billing [(subject to Administrative Fee of [\$1-\$10] per person per month)]]	<input type="radio"/> [Monthly EFT [(subject to [one time] Administrative Fee of [\$5 per person)]]  <input type="radio"/> [Monthly credit card draw [(subject to Administrative Fee of [\$1-\$10] per person per month)]]  <input type="radio"/> [Monthly billing [(subject to Administrative Fee of [\$1-\$10] per person per month)]]

[Payroll Deduction Program This program allows your premium to be deducted directly from your paycheck, post-taxes. Other details apply. To choose this option, you MUST submit a separate <CoventryOne>Payroll Deduction Authorization Form with your Application.]

<input type="radio"/> [NEW Payroll Deduction Program (PDP)]	<input type="radio"/> [EXISTING Payroll Deduction Program (PDP)] PDP number: _____ PDP name: _____
---	---

**EFT (Electronic Funds Transfer) Information** [Complete this section if you have chosen to pay by EFT. When choosing EFT, your monthly premium will be withdrawn automatically from the bank account listed on the [10<sup>th</sup>] day (or the next business day if a weekend/holiday) of the month for which premium is due. If the effective date is anything other than the 1<sup>st</sup> of the month, the initial premium will be prorated based on your effective date.]

<input type="radio"/> Checking Account <input type="radio"/> Savings Account	Name of account holder	9-digit routing number	Account number										
		<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>											
Name of bank / savings institution		Relationship of account holder to Primary Applicant <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Other _____											
Account holder address		City	State	ZIP									

**[Credit Card Information** [Complete this section if you have chosen to pay by credit card. If the effective date is anything other than the 1<sup>st</sup> of the month, the initial premium will be prorated based on your effective date.]]

<input type="radio"/> [VISA ] <input type="radio"/> [MasterCard]	[Name of card holder (exactly as on card)]	[Card number]	[Exp. date (mm/yyyy)]	[Verification code <sup>[1]</sup> ]
[Card billing address]		[City]	[State]	[ZIP]

**[Monthly Billing Information** [If you choose Monthly Billing, your bill will be sent to the Mailing Address you supplied in the [Primary Applicant Information] section on page [1]. [At this time, we are unable to bill you at an alternate address.]]

[1 The Verification Code for your Visa or MasterCard is a 3-digit code printed near the signature strip on the back of your card.]

[Important Note: [[CoventryOne] 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 [your agent] to complete a [CoventryOne Payroll Deduction Authorization Form].]

- By signing this Premium Payment section, you are agreeing to the following statements:
- You understand that it is your responsibility to notify <Plan> at [<insert #>] should your payment information change at any time while you continue to hold a <CoventryOne> policy.
  - You understand that if premium payment is returned unpaid, a fee will be assessed in the amount of [\$20.00]. You authorize <Plan> to collect the premium payment due between the [5<sup>th</sup>] and [15<sup>th</sup>] of the month, including any unpaid fee amount. Failure to remit the first payment rescinds the policy.
  - You understand that providing this payment information does not guarantee approval or coverage.
  - Upon approval and acceptance of this Application, you authorize <PLAN > to initiate automatic withdrawal and / or a billing cycle of applicable premium payments from your provided account or billing information. [Depending on your effective date, your first automatic withdrawal may include up to, but not in excess of, two times your monthly premium amount.]

Account / Card Holder Signature: _____	Date: _____
--	-------------

## Authorization of Release of Information

[I, the Applicant, for myself and any of my Dependents who are under the age of 18 and who 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 <PLAN> 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 <PLAN> to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by <PLAN> for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for <PLAN> 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 <PLAN> 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 <PLAN> to use or disclose the information I provide in this Application (or that the <PLAN> 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 <PLAN> prior to the date such revocation is received by <PLAN>.]

[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*	_____ Date	_____ Dependent Signature*	_____ Date
*Required age 18 and over.			
The below signature must be completed if this is a Child-Only Application.			
_____ Parent/Legal Guardian Signature	_____ Print Name	_____ Relationship to child applying for coverage	_____ Date