

SERFF Tracking Number: CVKS-127392375 State: Arkansas  
Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 49679  
Company Tracking Number:  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO  
Product Name: Enrollment Forms (Group)  
Project Name/Number: /

## Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: Enrollment Forms (Group) SERFF Tr Num: CVKS-127392375 State: Arkansas  
TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 49679  
Closed

Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor  
Author: Jennifer Simms Disposition Date: 09/02/2011  
Date Submitted: 08/30/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

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: Group  
Submission Type: New Submission Group Market Size: Small and Large  
Group Market Type: Employer Overall Rate Impact:  
Filing Status Changed: 09/02/2011  
State Status Changed: 09/02/2011 Deemer Date:  
Created By: Jennifer Simms Submitted By: Jennifer Simms  
Corresponding Filing Tracking Number:  
PPACA: Not PPACA-Related  
PPACA Notes: null  
Filing Description:  
Enrollment forms (employee) for group products

## Company and Contact

### Filing Contact Information

Jennifer Simms, Regulatory Compliance jesimms@cvty.com  
Analyst

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8320 Ward Parkway 866-795-3995 [Phone] 4539 [Ext]  
 Kansas City, MO 64114 816-460-4695 [FAX]

**Filing Company Information**

Coventry Health and Life Insurance Company CoCode: 81973 State of Domicile: Delaware  
 8320 Ward Parkway Group Code: 1137 Company Type: LAH  
 Kansas City, MO 64114 Group Name: Coventry Health Care State ID Number:  
 (866) 795-3995 ext. 4539[Phone] FEIN Number: 75-1296086

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$150.00  
 Retaliatory? No  
 Fee Explanation: 3 forms @ \$50 eac = \$150  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Coventry Health and Life Insurance Company	\$150.00	08/30/2011	51096229

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/02/2011	09/02/2011

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## **Disposition**

Disposition Date: 09/02/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Coverletter 2011 08 30	Approved-Closed	Yes
Form	Change Form/Enrollment Form	Approved-Closed	Yes
Form	Health Statement/Enrollment Form	Approved-Closed	Yes
Form	Waiver of Coverage	Approved-Closed	Yes

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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 09/02/2011	APP-CF-08.11	Application/Change Enrollment Form	Form/Enrollment Form	Revised	Replaced Form #: APP-CF-05.11 Previous Filing #: CVKS-127187464		APP-CF-08.11.pdf
Approved-Closed 09/02/2011	APP-HS-08.11	Application/Health Enrollment Form	Statement/Enrollment Form	Revised	Replaced Form #: APP-HS-05.11 Previous Filing #: CVKS-127187464		APP-HS-08.11.pdf
Approved-Closed 09/02/2011	APP-WVR-08.11	Application/Waiver of Coverage Enrollment Form		Initial			APP-WVR-08.11.pdf

**ENROLLMENT AND CHANGE FORM**

Important: \* Denotes required field or section.

DO NOT WRITE IN MARGINS



521 President Clinton Ave., STE 700; Little Rock, AR 72201

PH: 1-866-795-3995 - Fax: 1-866-287-6594

\*Plan:  PPO  QHDHP

Selection (Optional):  Base  Buy-up  Buy-down  Other: \_\_\_\_\_

*Group Name:	*Group Number:	*Effective Date / Date of Change:
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**\*Section A – Reason for Enrollment or Change:**

<input type="checkbox"/> New Group <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of Other Group Coverage <input type="checkbox"/> Name Change <input type="checkbox"/> Address/Phone Change <input type="checkbox"/> Dependent Address Change	<b>Add Dependent(s)</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> QMCSO <input type="checkbox"/> Other	<b>COBRA/State Continuation eligible due to:</b> <input type="checkbox"/> Termination of employment <input type="checkbox"/> Reduction in Work Hours <input type="checkbox"/> Divorce/Separation <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Death of Subscriber	<b>Cancel All Coverage</b> <input type="checkbox"/> Terminate Employment <input type="checkbox"/> Voluntary Withdrawal <input type="checkbox"/> Leave/Layoff <input type="checkbox"/> Out of Service Area <input type="checkbox"/> Other	<b>Cancel Dependent(s) Coverage only</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Age Limit <input type="checkbox"/> Out of Service Area <input type="checkbox"/> Other	<b>Reinstatement</b> <input type="checkbox"/> Return from Layoff <input type="checkbox"/> Return from leave <input type="checkbox"/> Rehire <input type="checkbox"/> Enrollment Error <input type="checkbox"/> Other
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**\*Section B – Employee Information (Please Print Clearly):**

*Last Name	*First Name	*MI	*Email Address	*Hire Date
*Address	*City, State	*Zip Code	*Phone	*Work phone

**\*Is the Employee on a Leave of Absence?**  No  Yes **\*if Yes, what type:**  FMLA  Worker's Compensation  Disability  Retired

*Last Name, First Name, MI Indicate if adding or canceling coverage	*Gender	*Birth Date MM/DD/YYYY	*Social Security Number	*Status	*Relationship to Employee	*Dependent Address if different from Employee
*Employee	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Active <input type="checkbox"/> On Leave	N/A	N/A
Spouse	<input type="checkbox"/> Add <input type="checkbox"/> Delete †	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Common Law ** <input type="checkbox"/> Disabled		
Child***	<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Lives with Employee <input type="checkbox"/> Disabled		
Child***	<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Lives with Employee <input type="checkbox"/> Disabled		
Child***	<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Lives with Employee <input type="checkbox"/> Disabled		

\*\* You must submit affidavit with Enrollment if indicating marriage under Common Law. \*\*\*For Dependent children eligible for Coverage under a Qualified Medical Child Support Order (QMCSO), you must submit the Medical Child Support order with Enrollment. † If applicable, submit any divorce decree and family court order so that order of benefit coordination may be determined promptly to prevent any delay in claim processing/payment.

**\*Section C – Coordination of Benefits**

**\*Other Medical/Rx Insurance Coverage:** When coverage begins, will you or any of your family members have any other insurance coverage?  Yes  No  
If yes, check all that apply  Medical  RX **List type:**  Commercial/Employer Group  Individual Policy  Medicare **What family members are covered?**  
 Self  Spouse  Child(ren) If not all, list: \_\_\_\_\_  
**Policy Holder:** \_\_\_\_\_ **Insurance Provider:** \_\_\_\_\_  
**Effective Date:** \_\_\_\_\_ **Medicare Eligibility due to:**  Age 65  Disability  Other **and Coverage includes:** Part  A  B  C  D

**\*Section D – Agreement and Authorization**

By signing this form, I am applying for covered services for which my family and I are eligible and I authorize my employer to deduct from my earnings any required contributions. I agree on behalf of myself and those family members enrolled (“Dependents”), for whom I have the authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as my “Enrolled Family”), that Coventry Health Care of Kansas, Inc. and Coventry Health and Life Insurance Company, and/or their authorized representatives (collectively referred to as “Health Plan”) may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering my health insurance benefit, including for treatment, payment or health care operations, as those terms are explained in detail in Health Plan’s Notice of Privacy Practices and to the extent permitted by law.

I also agree on behalf of myself and my Dependents, that, to the extent permitted by law, health care providers, insurers, claims administrators, employers and others may disclose my Enrolled Family’s personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, autoimmune deficiency syndrome, AIDS related complex, human immunodeficiency virus or genetic conditions to Health Plan for Health Plan’s administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law. This agreement shall remain valid for twenty-four (24) months.

I represent that my answers to the questions on this form are complete and accurate to the best of my knowledge, and I understand that my answers will be used to determine eligibility for coverage. If I, on behalf of myself and my Dependents, engage in gross misbehavior, intentional fraud or the making of intentional misrepresentation of material fact in applying for or seeking any benefits through the Health Plan, it could provide the basis to reform, refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force. After coverage has been in force for two years, no statement except fraudulent statements I make voids my coverage or reduces my benefits.

**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.**

**\*I have read and agree to the statements above.**

Employee Signature	Employee Printed Name	Date
_____	_____	_____

<b>Employer’s Authorized Representative</b> (required if employee is not available to sign)		
Signature	Printed Name and Title	Date
_____	_____	_____

**INCOMPLETE FORMS WILL BE RETURNED, DELAYING ELIGIBILITY, CLAIMS PROCESSING, RECEIPT OF ID CARDS(S) AND MAY RESULT IN DENIED CLAIMS**

PPO Plans *underwritten by* Coventry Health and Life Insurance Company and *administered by* Coventry Health Care of Kansas, Inc.

<b>Section A Employee Information</b> Please Print Clearly	*Last Name	*First Name	MI
	*Address	*City, State & Zip	
	County	*Phone ( )	
*Group/Employer Name		*Occupation	*Hire Date

*Work Phone ( )	*Email address	Plan Type
*Effective Date of Coverage:	*Employer Sub-Group Number	<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation Effective Date _____

Coverage Selection:  Employee Only  Employee + Spouse  Employee + Child(ren)  Employee + Family  
 Is Employee on Leave of Absence?  No  Yes \*If Yes, type?  FMLA  Worker's Compensation  Disability  Retired

*Last Name, First Name, MI and Gender	*Birth date MM/DD/YYYY	*Height	*Weight	*Social Security Number	*Status
Employee	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Active <input type="checkbox"/> On Leave
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Common Law ** <input type="checkbox"/> Disabled

*Relationship to Employee:	*Dependent Address if different from Employee:
Child***	<input type="checkbox"/> M <input type="checkbox"/> F
	<input type="checkbox"/> Lives with Employee <input type="checkbox"/> Disabled

*Relationship to Employee:	*Dependent Address if different from Employee:
Child***	<input type="checkbox"/> M <input type="checkbox"/> F
	<input type="checkbox"/> Lives with Employee <input type="checkbox"/> Disabled

*Relationship to Employee:	*Dependent Address if different from Employee:
Child***	<input type="checkbox"/> M <input type="checkbox"/> F
	<input type="checkbox"/> Lives with Employee <input type="checkbox"/> Disabled

\*\*You must submit affidavit if indicating marriage under Common Law. \*\*\* For Dependent children eligible for Coverage under a Qualified Medical Child Support Order (QMCSO), you must submit the Medical Child Support order.

**Section B - Other Insurance Coverage**

When coverage begins, will you or any Dependents have other insurance coverage?  Yes  No  
 If yes, check all that apply:  Medical  RX **List type:**  Commercial/Employer Group  Individual  Medicare  
**Policy Holder:** \_\_\_\_\_ **Which family members are covered?**  Self  Spouse  Child(ren)  
 If not all, list: \_\_\_\_\_

**Insurance Provider:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_  
**Medicare Eligibility due to:**  Age 65  Disability  Other **and** Coverage Includes: Part  A  B  C  D

INCOMPLETE FORMS WILL BE RETURNED, DELAYING ELIGIBILITY, CLAIMS PROCESSING, RECEIPT OF ID CARD(S) AND MAY RESULT IN DENIED CLAIMS

**Section C - Health Information** (for rating purposes only): Please provide the health history of yourself and your dependents listed in this enrollment form who has been diagnosed or treated **in the last 10 years for any of the conditions listed below** by placing a "X" in the appropriate boxes. Please further explain your selections in the Health Statement Table which follows. You should not include any of your and/or your dependent's family history or genetic information (including, but not limited to, genetic testing, genetic service, genetic counseling, or genetic diseases for which you and/or your dependents may be at risk).

<input type="checkbox"/> 1. AIDS/HIV	<input type="checkbox"/> 11. Physical Deformity or Defect	<input type="checkbox"/> 22. Liver (cirrhosis, hepatitis B, C, D, E)
<input type="checkbox"/> 2. Allergy/Asthma	<input type="checkbox"/> 12. Digestive/Intestinal Disorder	<input type="checkbox"/> 23. Mental or Nervous Disorder
<input type="checkbox"/> 3. Arthritis	<input type="checkbox"/> 13. Drug or Alcohol Abuse	<input type="checkbox"/> 24. Migraine Headaches
<input type="checkbox"/> 4. Bladder/Urinary Disorder	<input type="checkbox"/> 14. Eating Disorder	<input type="checkbox"/> 25. Neck, Back, or Spine Disorder
<input type="checkbox"/> 5. Blood, Bleeding, or Clotting Disorder	<input type="checkbox"/> 15. Endocrine/Pancreatic Disorder	<input type="checkbox"/> 26. Organ Transplant
<input type="checkbox"/> 6. Bone/Joint/Muscular Disorder	<input type="checkbox"/> 16. Eye, Ear, Nose, or Throat Disorder (excluding glasses)	<input type="checkbox"/> 27. Respiratory/Lung Disorder
<input type="checkbox"/> 7. Cancer	<input type="checkbox"/> 17. Heart/Circulatory Disorder	<input type="checkbox"/> 28. Skin Disorder
<input type="checkbox"/> 8. Cyst	<input type="checkbox"/> 18. High Blood Pressure	<input type="checkbox"/> 29. Stroke/Nervous System/Brain Disorder
<input type="checkbox"/> 9. Current Pregnancy: Due Date _____	<input type="checkbox"/> 19. High Cholesterol	<input type="checkbox"/> 30. Tumor
<input type="checkbox"/> 10. Diabetes	<input type="checkbox"/> 20. Infertility	<input type="checkbox"/> 31. Tobacco Product Use
	<input type="checkbox"/> 21. Kidney Disorder (dialysis or failure)	<input type="checkbox"/> 32. Vascular (blood vessel) Disorder

Please answer Yes or No to the following questions. Please explain any "Yes" responses in the Health Statement table below.

Yes  No 33. Have you or any dependent received inpatient or outpatient services in the last five (5) years (exclude routine tests, physicals, or inoculations)

Yes  No 34. Do you or any dependent have tests, treatments, hospitalization, surgery planned/recommended in future?

Yes  No 35. Do you or any dependent take any medicine, prescription drugs, or require shots/injections?

Yes  No 36. Do you or any dependent have any other medical conditions which have not yet been previously mentioned?

**Health Statement Table - Give full details for all "X" or "Yes" responses. If needed, attach additional pages with date and signature.**

Question # & Person's Name	Diagnosis and Dates of Treatment	Medications/Treatment	Doctor's Name

**Section D - Agreement and Authorization:** By signing this form, I am applying for covered services for which my family and I are eligible and I authorize my employer to deduct from my earnings any required contributions. I agree on behalf of myself and those family members enrolled ("Dependents"), for whom I have the authority to enroll and to consent on their behalf (collectively my Dependents and I shall be referred to as my "Enrolled Family"), that Coventry Health Care of Kansas, Inc. and Coventry Health and Life Insurance Company, and/or their authorized representatives (collectively referred to as "Health Plan") may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to my Enrolled Family for purposes of administering my health insurance benefit, including for treatment, payment or health care operations, as those terms are explained in detail in Health Plan's Notice of Privacy Practices and to the extent permitted by law. I also agree on behalf of myself and my Dependents, that, to the extent permitted by law, health care providers, insurers, claims administrators, employers and others may disclose my Enrolled Family's personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, autoimmune deficiency syndrome, AIDS related complex, human immunodeficiency virus or genetic conditions to the Health Plan for Health Plan's administration of health insurance benefits, including for treatment, payment or health care operations purposes and other purposes permitted by law. This agreement shall remain valid for twenty-four (24) months. I represent that my answers to the questions on this form are complete and accurate to the best of my knowledge, and I understand that my answers, except those for rating purposes only, will be used to determine eligibility for coverage. If I, on behalf of myself and my Dependents, engage in gross misbehavior, intentional fraud or the making of intentional misrepresentation of material fact in applying for or seeking any benefits through the Health Plan, it could provide the basis to reform, refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force. After coverage has been in force for two years, no statement except fraudulent statements I make voids my coverage or reduces my benefits. 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.

**\*I have read and agree to the statements above.** Employee Signature \_\_\_\_\_

\*Employee Printed Name \_\_\_\_\_ \*Date \_\_\_\_\_

PPO Plans *underwritten* by Coventry Health and Life Insurance Company and *administered* by Coventry Health Care of Kansas, Inc.



## EMPLOYEE DECLINATION OF COVERAGE FORM

Important: \* Denotes required field or section. Please do not write in margins.

521 President Clinton Ave., STE 700; Little Rock, AR 72201

PH: 1-866-795-3995 - Fax: 1-866-287-6594

*Employee Last Name		*Employee First Name		MI	Home Phone ( )
*Address		*City, State		*Zip	County
*Group/Employer Name		*Occupation		*Hire Date	*Work Phone ( )
*Effective Date of Coverage:	*Employer Sub-Group Number	<input type="checkbox"/> New Group <input type="checkbox"/> COBRA   Effective Date _____ <input type="checkbox"/> State Continuation			Email address
*I Waive Medical Coverage for: <input type="checkbox"/> Employee & Any Eligible Dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)		*Reason waiving coverage: <input type="checkbox"/> Covered by other group medical insurance. Please list insurer: _____ <input type="checkbox"/> Other reason (please explain): _____			
<p>If you are waiving/declining medical coverage for yourself or your dependents (including your spouse) because of other medical coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after a marriage, birth, adoption or placement for adoption or within 60 days after losing eligibility for any CHIP or Medicaid subsidy or becoming eligible for any CHIP or Medicaid subsidy. If you are waiving medical coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period [and a preexisting condition exclusion period may apply].</p>					
<p><b>I hereby decline coverage as indicated above</b></p>					
*Employee Signature _____ Employee Printed Name _____ Date _____					
PPO Plans <i>underwritten</i> by Coventry Health and Life Insurance Company and <i>administered</i> by Coventry Health Care of Kansas, Inc..					

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## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Flesch Certification	Approved-Closed	09/02/2011
<b>Bypass Reason:</b>	n/a to this filing.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Approved-Closed	09/02/2011
<b>Bypass Reason:</b>	n/a to this filing.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	PPACA Uniform Compliance Summary	Approved-Closed	09/02/2011
<b>Bypass Reason:</b>	n/a to this filing.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Coverletter 2011 08 30	Approved-Closed	09/02/2011
<b>Comments:</b>			

All forms contain bracketed variables around Coventry Health Care of Kansas, Inc. ("CHC-KS"), a subsidiary of Coventry Health Care, Inc. CHC-KS is intended to be the administrator of this product.

All forms contain bracketed variables around the address, phone, and website information. This is intended to be modifiable as necessary, should this product be administered by another Coventry Health Care company maintaining Arkansas licensure.

Form APP-CF-08.11 = change and enrollment forms for post-enrollment processes and new large employer groups.

Form APP-HS-08.11 = health statement form for underwriting purposes, and subsequent enrollment of initial

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enrollment/new employer group

Form APP-WVR-08.11 = waiver of coverage form for employees electing NOT to enroll in coverage for either/or themselves and any eligible dependents.