

SERFF Tracking Number: CVKS-128539222 State: Arkansas  
Filing Company: Coventry Health and Life Insurance Company State Tracking Number:  
Company Tracking Number: AR-APP-CF-06.12  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO  
Product Name: Enrollment and Change Form 2012  
Project Name/Number: /

## Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: Enrollment and Change Form 2012 SERFF Tr Num: CVKS-128539222 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- Closed State Tr Num:

Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: AR-APP-CF-06.12 State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Vanda Johnson, Paula Bostock, Lisa Foos Disposition Date: 07/06/2012

Date Submitted: 07/03/2012 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

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: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 07/06/2012

State Status Changed: 07/06/2012

Deemer Date:

Created By: Vanda Johnson

Submitted By: Vanda Johnson

Corresponding Filing Tracking Number: CVKS-127392375

PPACA: Not PPACA-Related

PPACA Notes: null

Healthcare.gov ID:

Filing Description:

Please find attached a revised Enrollment and Change Form. The form was previously approved by your office on 9/2/2011 - SERFF CVKS-127392375, form APP-CF-08.11.

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\*The Company name is added above the address.

\*Plan types are made variable and Selection of plan titles is expanded to accommodate various group's preferences and business practices (e.g. base/premium, buy-up/down etc.). "Optional" is also removed from the Selection of plan titles as this is not indicated as a required field by an asterik.

\*Group Name, Group Number and Effective Date/Date of Change is now in bold

\*Section A - a 'for example' list is added to help in understanding what this form covers and a note is added that the Effective Date is required.

\*Section A - Reinstatement sub-section is moved to position #3 and COBRA/State Continuation is moved to position #6

\*To make the most of limited space, "indicate Gender" is added directly after Last Name, First Name, Middle Initial

\*Removed "Relationship to Employee" column as "spouse", "child" is already indicated in the corresponding rows

\*Dependent Address note in regards to when the address differs from the Employee is moved to the bottom of page 1

\*Primary Care Physician ID# column is added

Page 2 -

\*Section D - Fraud statement - the statement is revised to state "determined by a court of law".

If you have any questions, please do not hesitate to contact me at 703-794-7755 or Lisa Foos at 316-609-2564.  
Thank you for your attention to this filing.

Sincerely,

Vanda Johnson

Policy and Compliance Specialist

State Narrative:

## Company and Contact

### Filing Contact Information

Lisa Foos, Manager, Regulatory Compliance lfoos@phsystems.com  
8535 E. 21st St. N. 316-609-2564 [Phone]  
Wichita, KS 67206

### 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: \$50.00  
Retaliatory? No  
Fee Explanation: \$50/form  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Coventry Health and Life Insurance Company	\$50.00	07/03/2012	60644463

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/06/2012	07/06/2012

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## **Disposition**

Disposition Date: 07/06/2012

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
Form	Enrollment and Change Form 2012	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 07/06/2012	AR-APP-CF-06.12	Application/Enrollment and Enrollment Change Form	Application/Enrollment and Change Form 2012	Initial			AR-APP-CF-06.12.pdf

**ENROLLMENT AND CHANGE FORM** Important: \* Denotes required field or section. DO NOT WRITE IN MARGINS

[Coventry Health and Life Insurance Company  
521 President Clinton Ave, STE 700, Little Rock, AR 72201]  
PH: 1-866-647-1551 - Fax: 1-501-372-0211]

[LOGO]

\*Plan:  PPO  QHDHP      Selection:  Base  Premium  Buy-up  Buy-down  Option [1]  Option [2]  Option [3]  Other: \_\_\_\_\_ ]

<b>*Group Name:</b>	<b>*Group Number:</b>	<b>*Effective Date / Date of Change:</b>
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**\*Section A – Reason for Enrollment or Change** (e.g. new hire, electing COBRA, etc.) *Effective Date for Enrollment, Change, or Qualifying Event is Required Above.*

<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 Dependents</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> QMCSO <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	<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>COBRA or State Continuation election 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
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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, Middle Initial and indicate Gender Check appropriate box for adding or canceling coverage	*Birth Date MM/DD/YYYY	*Social Security Number	*Status	*Dependent Address††	[*Primary Care Physician ID#]
*Employee <input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Active <input type="checkbox"/> On Leave	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. †† Include if dependent address is different from Employee.

**\*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. dba Preferred Health Systems, Coventry Health and Life Insurance Company, dba Preferred Health Systems, 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 fraud as determined by a court of law.**

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

Employee Signature	Employee Printed Name	Date
_____	_____	_____

**Employer’s Authorized Representative** (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.

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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> Please see attached Flesch Certification <b>Attachment:</b> AR_APP-CF-06.12_Flesch_Certification.pdf	Approved-Closed	07/06/2012
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> not applicable - filing is for enrollment/change form <b>Comments:</b>	Approved-Closed	07/06/2012
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary <b>Bypass Reason:</b> not applicable - enrollment/change form filing only <b>Comments:</b>	Approved-Closed	07/06/2012

