GROUP ENROLLMENT & CHANGE FORM

Products are underwritten by Coventry Health Care of Missouri, Inc. ("Coventry Health Care") and/or Coventry Health and Life Insurance Co.
550 Maryville Centre Drive, Suite 300, St. Louis, MO 63141

Incomplete information may delay the processing of your enrollment and/or your member ID card.

EMPLOYER INFORMATION: To Be Completed By Employer

Company Name:	Group No. (10 digits):	Date Employed Full Time:	Effective Date of Coverage:	Benefits Administrator Approval:	Date:
Employers & Laborers' Local 100 & 397 Health & Welfare Fund	enter Member Number from id card:		1/1/2016		

Reason for Enrollment: ❑ New Group ❑ New Hire ❑ Open Enrollment ❑ Cobra ❑ Hardship ❑ Other:________

Reason for Change: ❑ Addition ❑ Address/Phone ❑ Coverage ❑ Termination Reason & Date:________ ❑ PCP Change Reason:________ ❑ Other:________

Type of Coverage: ❑ Employee ❑ Employee Spouse ❑ Employee/Children ❑ Employee/Spouse/Children ❑ Waive

Employee Status: ❑ Hourly ❑ Salary ❑ Retired ❑ Other________

EMPLOYEE INFORMATION: To Be Completed By Employee

If address and phone numbers of covered dependents are different from that of policy holder, please attach the information on a separate sheet of paper.

Last Name:	First Name:	MI:	Social Security Number:

Street Address:	Work Phone & Area Code:

City:	State:	Zip Code:	Home Phone & Area Code:

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Product Slections (Please write in plan number):
- ❑ HMO[1]: ________
- ❑ POS[2]: ________
- ❑ Open Access HMO[3]: ________
- ❑ Open Access POS[4]: ________
- ❑ PPO[5]: ________
- ❑ Carelink Select[6]: ________
- ❑ IL Plus[7]: ________
- ❑ Carelink from Coventry[8]: ________

MEMBER INFORMATION: Family Members to be Covered and Physician Selection

All areas below must be filled out for each family member or it will delay processing enrollment. If "other" is checked, please indicate the nature of that relationship and include any appropriate legal documents. ***Note: PPO and Sensicare members do not need to select a physician. For Carelink from Coventry plans, selecting a Primary Care Physician is required.** *__Attention Female Illinois Members:__ **You may designate an IL OB-Gyn as your Women's Principal Health Care Provider (WPHCP), in addition to your Primary Care Physician (PCP). Please write your WPHCP choice in the box labeled OB-Gyn name.**

Relationship	Add/ Delete	Last Name	First Name	M.I.	Social Security Number	Sex	Date of Birth Month	Day	Year	Primary Care Name and I.D. Number	Current Patient	*OB-GYN Name	Height/ Weight
❑ Self	❑ Add ❑ Delete					❑ M ❑ F				Name I.D. #	❑ Y ❑ N		H: W:
❑ Husband ❑ Wife	❑ Add ❑ Delete					❑ M ❑ F				Name I.D. #	❑ Y ❑ N		H: W:
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				Name I.D. #	❑ Y ❑ N		H: W:
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				Name I.D. #	❑ Y ❑ N		H: W:
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				Name I.D. #	❑ Y ❑ N		H: W:
❑ Son ❑ Daughter ❑ Other	❑ Add ❑ Delete					❑ M ❑ F				Name I.D. #	❑ Y ❑ N		H: W:

OTHER HEALTH INSURANCE INFORMATION: Complete or Write N/A

Name of Policyholder:	Birthdate (mo/day/yr):	Social Security Number:
Name of Employer:		
Name of Insurance Company of Health & Welfare Plan:	Insurance Company Phone Number:	Effective Date:
Insurance Company Claim Address:	Insurance Policy Number:	Group Number:
List of Family Members Covered:	Covered and on Medicare:	Beneficiary Number:
		Medicare A Eff. Date:
		Medicare B Eff. Date:

AGREEMENT: Please read the following carefully.

1. I apply for membership in or waiver of Coventry Health Care for myself and for any eligible dependents listed. If enrolled, I authorize my employer to make deductions, if any, toward the premium cost of Coventry Health Care.
2. When enrolled, I and my eligible dependents shall abide by the provisions of coverage in the Group Enrollment Agreement, Certificate of Coverage and Benefit Riders under which we are enrolled.
3. By signing this form, I authorize my employer, & any physician, hospital, medical group or other facility providing me care, treatment or consultation, to disclose to Coventry Health Care, or receive from Coventry Health Care, any medical or claim information pertaining to the persons identified in this enrollment form receiving or applying for coverage under this plan, as may be necessary to enable Coventry Health Care to make coverage determinations, pay claims or otherwise administer plan programs, including without limitation, credentialing of physicians and as applicable, other providers, all of which shall be conducted in accordance with state and federal confidentiality laws. Coventry Health Care will not disclose any information pertaining to HIV/AIDS or chemical dependency/substance abuse except as specifically permitted by applicable law.
4. I understand and agree no benefits shall take effect until this application is approved by Coventry Health Care.
5. I understand that my membership may be cancelled for one or both of the following reasons: (1) failure to pay the amount due under the Group Enrollment Agreement or Certificate of Coverage, for which I am legally responsible, or (2) fraud or material misrepresentation in enrollment or in the use of services of facilities.
6. I understand that it is my responsibility to report to Coventry Health Care any change in the eligibility of myself or my dependents.

By signing this form I certify ALL information given is true and accurate.

Applicant's Signature:________________ Date:________

[1] HMO - underwritten by Coventry Health Care
[2] POS - HMO underwritten by Coventry Health Care; Out-of-Network underwritten by Coventry Health & Life Insurance Co.
[3] Open Access HMO - underwritten by Coventry Health Care
[4] Open Access POS - Benefits underwritten by Coventry Health & Life Insurance Co.
[5] PPO - underwritten by Coventry Health & Life Insurance Co.
[6] Carelink Select - underwritten by Coventry Health & Life Insurance Co.
[7] IL Plus - HMO underwritten by Coventry Health Care; Out-of-Network underwritten by Coventry Health & Life Insurance Co.
[8] Carelink from Coventry - PPO underwritten by Coventry Health and Life Insurance Company

7850-31 (100+)

MO Department of Insurance Approved 11/9/11

GENERAL PROVISIONS

1. ENROLLMENT RIGHTS NOTICE (Waived Coverage)

   I understand that if I and/or any of my dependents, if any, waive coverage at this time and desire to participate in the plan at a future date, coverage could be subject to treatment as a late enrollee at that time. I further understand that even if I decline enrollment for myself or my dependents, spouse included, because of other health coverage at this time, I will still have the right to enroll myself and/or my dependents in this plan, provided I request enrollment within thirty-one (31) days of the time that such coverage ends. I also understand that if a new dependent relationship is formed due to marriage, birth, adoption, placement for adoption, or court order, I may be able to enroll myself and/or my dependents provided I request enrollment within thirty-one (31) days of such marriage, birth, adoption, placement for adoption or court order.

2. RESOLUTION OF DISPUTES

   Please refer to the Certificate of Coverage, which outlines in detail Coventry Health Care's Member Grievance and Appeals Procedure.

FOR HEALTH PLAN USE ONLY			
Group Number:	Subscriber No.:	Date Entered/By:	Effective Date: