Use This Checklist To Make Sure Your CoventryOne Application is Complete

_____ ***1. One application may be completed for an entire family (applicant, spouse and dependent children)***

_____ ***2. Completed bank draft agreement - If not paying with monthly bank draft, $5 will be added to each monthly premium as a service charge. Also, if not paying by bank draft for first payment, you must include a check made payable to COVENTRY in the amount of the first months premium***

_____ ***3. All adult applicants must sign and date the application***

_____ ***4. <u>All</u> questions must be answered. Any corrections or scratched out areas must be initialed.***

_____ ***5. Once application is completed, you may fax your application to us at 770-396-4318 if paying by bank draft. If you do not receive a confirmation call or email by the end of the next business day after your fax, please call.***

If paying by check or unable to fax your application, mail all of the above to:
Insurance Now
5 Dunwoody Park S.
Suite 113
Atlanta, GA 30338

Please call with any questions you may have.
(770) 396-9517 or toll-free at (877) 711-8376
Thank you

CoventryOne. Underwritten by Coventry Health Care of Georgia, Inc.

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.

Check all that apply:

☐ New Application ☐ Add a Dependent ☐ Plan Benefits Increase

Coventry*One*
Received Date: _____

Submit Completed Applications for Health Coverage to: Insurance Now
5 Dunwoody Park S., #113
Atlanta, GA 30338
Or email holly@insurance-now.com
Or by fax at:
770-396-4318
Questions? Call 770-396-9517

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.

$30 Copay POS
☐ $1,750
☐ $2,750
☐ $3,750
☐ $5,750

$35 Copay POS
☐ $1,750
☐ $2,750
☐ $3,750
☐ $5,750
☐ $7,500 Basic
☐ $10,000 Basic

$45 Copay POS No Rx Deductible
☐ $1,750
☐ $2,750
☐ $3,750
☐ $5,750

$45 Copay POS With Rx Deductible
☐ $1,750
☐ $2,750
☐ $3,750
☐ $5,750

QHDHP Plans
☐ $3,000/$6,000
☐ $5,000/$10,000

Fusion POS
☐ $3,000
☐ $5,000

Health Savings Account (HSA) Selection If you have selected a Coventry*One* Qualified High-Deductible Health Plan (QHDHP), you are eligible to open a Health Savings Account (HSA) through our HSA trustee, Health Equity, upon approval.

☐ **I elect to have an HSA opened through HealthEquity**

Other Options The below additions are optional. Please note that additional premium may apply.

☐ Mental Health Rider – this rider is optional with Copay and Fusion Plans only, **for an additional cost**. Mental Health benefits are built into QHDHPs.
☐ Consumer Choice Option, for an additional cost.
☐

Requested Effective Date Requested Effective Date must be after, but no MORE than sixty (60) days past the signature date of the Application. Requested Effective Date is not guaranteed.

☐ **Day of Coventry*One* Approval OR**

☐ ___ / ___ / **20**____ (mm/dd/yyyy)

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.

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: ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime (8am-8pm) ( ) -	
E-mail address *(if we may correspond with you via E-mail)*	☐ Check here to opt out of receiving your policy and other pertinent documents by e-mail				

Primary Applicant Name: _____ **Agent Name:** __Insurance Now-770-396-9517

Applicant and Dependent Information

General Information List all individuals applying for health coverage in this section. 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)	Birthdate (mm/dd/yyyy)	Gender (M or F)	Height (ft. in.)	Weight (lbs.)	Tobacco use in past 12 months?[1]	U.S. residency for past six (6) months?[2]
1	**Primary Applicant**					☐ Yes ☐ No	☐ Yes ☐ No
	SSN#						
2	**Spouse**					☐ Yes ☐ No	☐ Yes ☐ No
	SSN#	Home address (if different from Primary Applicant)					
3	**Dependent Child**					☐ Yes ☐ No	☐ Yes ☐ No
	SSN#	Home address (if different from Primary Applicant)					
4	**Dependent Child**					☐ Yes ☐ No	☐ Yes ☐ No
	SSN#	Home address (if different from Primary Applicant)					
5	**Dependent Child**					☐ Yes ☐ No	☐ Yes ☐ No
	SSN#	Home address (if different from Primary Applicant)					
6	**Dependent Child**					☐ Yes ☐ No	☐ Yes ☐ No
	SSN#	Home address (if different from Primary Applicant)					

[1]'Tobacco use' constitutes use of tobacco or tobacco cessation products in the past twelve (12) months.
[2] 'U.S. residency" refers to the designated individual living legally in the United States for the past six (6) months

1 Prior Insurance Coverage

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. ☐ Yes ☐ No

_____

Primary Applicant Name: _____ **Agent Name:** __Insurance Now-770-396-9517

Medical Information

The Medical Details section requires your careful attention to each question. The questions below should be answered by you and not by any broker representing you. If you fail to provide truthful or accurate health history information, Coventry*One* may not issue coverage or may rerate, terminate, or rescind your coverage. You may want to consult your physicians 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.

1 Physical Exam	
Has any individual applying for coverage had a physical or wellness exam within the past two (2) years? If "Yes," provide details in the Medical Details section.	☐ **Yes** ☐ **No**
2 Pregnancy	
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?	☐ **Yes** ☐ **No**
3 Female Health History	
3a. Has any female applying for coverage had a Pap smear/pelvic exam within the last two (2) years? If "Yes," indicate results of exam: ☐ Normal ☐ Abnormal (If abnormal, complete the Medical Details Section)	☐ **Yes** ☐ **No**
3b. Has any female applying for coverage had a mammogram within the last two (2) years? If "Yes," indicate results of exam: ☐ Normal ☐ Abnormal (If abnormal, complete the Medical Details Section)	☐ **Yes** ☐ **No**
4 Transplants	
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.	☐ **Yes** ☐ **No**
5 HIV / ARC / AIDS	
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?	☐ **Yes** ☐ **No**

Check all that apply. In the past five (5) years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms that caused them or would cause an ordinarily prudent person to be treated or tested for by a medical professional, been advised by a medical professional to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised by a medical professional 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.

6 Cancer / Cyst / Tumor		
☐ Carcinoma, sarcoma, leukemia, lymphoma, myeloma, central nervous system cancers or carcinoma in situ	☐ Cyst, growth, lump, mass, tumor or polyp ☐ Other	☐ **None**
7 Respiratory System		
☐ Allergies or asthma ☐ Emphysema or chronic lung disease (COPD)	☐ Sleep apnea ☐ Other	☐ **None**
8 Cardiovascular and Circulatory System		
☐ Hypertension or high blood pressure ☐ Deep Venous Thrombosis or phlebitis ☐ Varicose veins, blood clot or aneurysm	☐ Irregular heartbeat, heart murmur, or mitral valve prolapse ☐ Heart attack, chest pain or angina ☐ Other	☐ **None**
9 Digestive System		
☐ Chronic abdominal pain, ulcer, acid reflux or hiatal hernia ☐ Diverticulitis, diverticulosis, hemorrhoids, or hernia ☐ Disorder of the esophagus, stomach, colon, rectum, intestine, bowel, gallbladder or pancreas	☐ Liver condition or hepatitis A ☐ Cirrhosis, fatty liver or hepatitis B or C ☐ Surgical treatment for obesity, gastric bypass or banding ☐ Other	☐ **None**
10 Emotional or Mental Health		
☐ Anxiety or depression ☐ Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder ☐ Bipolar disorder	☐ Obsessive Compulsive Disorder, schizophrenia ☐ Eating disorder ☐ Therapy or counseling ☐ Other	☐ **None**

11 Muscular or Skeletal System		
☐ Bursitis, tendonitis or gout ☐ Disorder of the back, neck or spine ☐ Connective tissue disorder, systemic lupus, rheumatoid arthritis ☐ Fibromyalgia ☐ Disorder of the knee, shoulder, hip or other joint ☐ Osteoarthritis, osteoporosis or osteopenia	☐ Temporomandibular joint disorder (TMJ) ☐ Fractures or broken bones ☐ Prosthetic limbs or devices, or internal fixations(pins, plates, screws) ☐ Any chiropractic treatments ☐ Other	☐ None
12 Skin		
☐ Acne or rosacea ☐ Eczema or psoriasis	☐ Abnormal or cancerous moles, melanoma ☐ Other	☐ None
13 Eyes / Ears / Nose / Throat		
☐ Disease or injury of eye ☐ Cataracts or glaucoma ☐ Ear disorder, ear infections or tubes in ears ☐ Hearing loss or cochlear implant	☐ Deviated septum or sinus infection ☐ Disorder of the throat, tonsils or adenoids ☐ Other	☐ None
14 Kidney or Urinary Tract		
☐ Bladder or urinary tract infection or disorder ☐ Kidney infection or disorder	☐ Kidney or bladder stones ☐ Other	☐ None
15 Female Reproductive System		
☐ Disorder of the breast or abnormal mammogram ☐ Saline breast implants ☐ Silicone breast implants ☐ Abnormal Pap smear ☐ Endometriosis, uterine fibroids or uterine prolapse	☐ Infertility or complications of pregnancy ☐ Menopausal disorder ☐ Menstrual disorder ☐ Cervical, ovarian, uterine or vaginal disorder ☐ Other	☐ None
16 Male Reproductive System		
☐ Infertility ☐ Penile or testicular disorder	☐ Prostate disorder, elevated PSA, Prostatitis ☐ Other	☐ None
17 Sexually Transmitted Diseases		
☐ Chlamydia ☐ Genital warts ☐ Genital herpes	☐ Human Papilloma Virus (HPV) ☐ Gonorrhea or syphilis ☐ Other	☐ None
18 Blood / Adrenal / Endocrine / Pituitary / Thyroid		
☐ Anemia ☐ Diabetes ☐ Elevated blood sugar ☐ Elevated cholesterol or triglycerides	☐ Endocrine, adrenal, or pituitary disorder ☐ Weight disorder ☐ Thyroid disorder ☐ Other	☐ None
19 Brain or Nervous System		
☐ Concussion or head injury ☐ Migraines or chronic headaches ☐ Convulsions, seizures, epilepsy, fainting, tics or tremors	☐ Stroke, Transient Ischemic Attack (TIA) or paralysis ☐ Multiple sclerosis ☐ Other	☐ None
20 Congenital or Development		
☐ Cleft palate or cleft lip ☐ Developmental disorder or delay	☐ Mental retardation, autism, or Down's Syndrome ☐ Other	☐ None
21 Alcohol / Drug		
☐ Alcohol abuse, dependency or alcoholism ☐ Drug / substance abuse or dependency	☐ A citation or conviction for driving under the influence of alcohol or any drug / substance ☐ Other	☐ None

22 Other Conditions	
In the past five (5) years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms that caused them or would cause an ordinarily prudent person to be treated or tested for by a medical professional, been advised by a medical professional to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised by a medical professional 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.	☐ Yes ☐ 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/yyyy)	Date of Recovery (mm/yyyy)	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		
	Treating Physician's Name	Address	Phone Number		

Medications

Please provide COMPLETE details for all medications (prescription or over-the-counter, or injectables) currently being taken or that have been taken by (including samples), or were prescribed or recommended by a medical professional for any individual applying for coverage in the past twelve (12) 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/yyyy)	Date Discontinued (mm/yyyy)	Medication Name	Dosage and Frequency	Condition / Reason for taking

Primary Applicant Name: _____ **Agent Name:** __Insurance Now-770-396-9517

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. 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. 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. Coventry may rescind coverage only in cases of fraud or intentional misrepresentation of a material fact. 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 change of rate, 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 Coventry*One* 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.

DO NOT cancel your existing health coverage until Coventry has notified you in writing that your coverage with Coventry is effective. Please retain a copy of this application for your records.

Any person who knowingly or willfully presents a false or fraudulent statement or representation of any material fact or thing in the filing of a claim for payment of a loss or benefit or knowingly presents false information in an application for insurance commits the crime of insurance fraud, which is a felony, and will be punished by imprisonment, or by fine, or both.

Primary Applicant's Signature	**Date**	**Spouse's Signature** (if applying for coverage)	**Date**
Dependent Signature[1]	**Date**	**Dependent Signature**[1]	**Date**

The below signatures must be completed if any child applying for health coverage (under the age of 18) has a Custodial Parent[2] **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[2]	**Print Name**	**Name of child(ren) to whom this applies**	**Date**

[1]Dependent Signature is required for individuals applying for coverage ages 18 and over.
[2]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- Holly G. Conley	Agent ID# (GA Insurance License#) -416743	Agent E-mail: holly@insurance-now.com
Agency name - Insurance Now	Agent / Agency phone - 770-396-9517	
Payee (who is paid commissions) ☐ Agent ☒Agency	Payee Tax ID# - 58-2176207	
Agent Signature Holly G Conley	**Date**	

Primary Applicant Name: _____ **Agent Name:** __Insurance Now-770-396-9517

Premium Payment

Initial Premium Payment Options Choose **ONE** payment option for initial payment. You must then complete the applicable section regarding your account information.

☐ EFT	☐ Check	

Ongoing Premium Payment Options Choose **ONE** payment option for ongoing payment. You must then complete the applicable section regarding your account information.

☐ **Monthly EFT** (no administrative fee)

☐ **Monthly statement billing** (subject to Administrative Fee of $5 per month)

Payroll Deduction Program (PDP) / Employer List Bill (ELB) 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 Payroll Deduction Authorization Form with your Application.

☐ **NEW Payroll Deduction Program (PDP) / Employer List Bill (ELB)**	☐ **EXISTING Payroll Deduction Program (PDP) Employer List Bill (ELB)** PDP number: _____ PDP name: _____]

EFT (Electronic Funds Transfer) Information Complete this section if you have chosen to pay by EFT. The first month's premium will automatically be withdrawn from the listed bank account upon acceptance. Thereafter, the monthly premiums will be withdrawn automatically on the 5th day (or next business day if a weekend or holiday) of the month for which premium is due. The premium amount due is calculated per day, so if the effective date is anything other than the 1st] of the month, the initial premium will be prorated.

☐ Checking Account ☐ Savings Account	[Name of account holder]	9-digit routing number	Account number
Name of bank / savings institution		Relationship of account holder to Primary Applicant ☐ Self ☐ Spouse ☐ Other_____	
Account holder address		City	State / ZIP

Statement Billing Information If you choose Statement Billing, your bill will be sent to the Mailing Address you supplied in the Primary Applicant

Important Note: Coventry*One* 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 us / your agent to complete a CoventryOne Payroll Deduction / Employer List Bill (ELB) Authorization Form.

By signing this Premium Payment section, you are agreeing to the following statements:

- You understand that it is your responsibility to immediately notify Coventry*One* at 1-866-364-5663 should your payment or address information change at any time while you continue to hold a Coventry*One* policy.
- You understand that if premium payment is returned unpaid, a fee will be assessed in the amount of $20.00. Failure to remit the first payment could result in rescission back to your effective date.
- You understand that providing this payment information does not guarantee approval or coverage.
- Upon approval and acceptance of this Application, you authorize Coventry*One* to initiate an immediate automatic withdrawal and / or a billing cycle of applicable premium payments from your provided account or billing information. If your effective date is entered into the system after the third business day of the month, your first automatic withdrawal may include premium amounts for multiple months.
- I agree this authorization will remain in effect until I provide written notification terminating this service.

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

Primary Applicant Name: _____ **Agent Name:** __Insurance Now-770-396-9517

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 licensed physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, insurance company, claims administrator, employer, governmental agency or other person or firm, to disclose to Coventry*One* 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.

List of Providers For the purposes of obtaining medical records if they are required to process your Application, please provide the following information about all provider(s) that are involved in the care of any individual applying for coverage. **Please provide information for all providers, even if previously mentioned on this Application.** 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.

Provider Name (Last, First)	Provider Address	City	State	ZIP

In addition, I authorize Coventry*One* to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by Coventry*One* for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for Coventry*One* 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 Coventry*One* 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 Coventry*One* to use or disclose the information I provide in this Application (or that the Coventry*One* 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 Coventry*One* prior to the date such revocation is received by Coventry*One*.

Coventry will not condition treatment, payment, or eligibility of benefits on whether the individual signs the authorization. However your application will not be underwritten unless you execute this form.

By signing this Authorization of Release of Information, I am authorizing any physician(s) and / or medical professional(s) including but not limited to those providers listed herein, to disclose the information as described above.

ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT STATEMENT OR REPRESENTATION OF ANY MATERIAL FACT OR THING IN THE FILING OF A CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE COMMITS THE CRIME OF INSURANCE FRAUD, WHICH IS A FELONY, AND WILL BE PUNISHED BY IMPRISONMENT, OR BY FINE, OR BOTH.

Primary Applicant's Signature	**Date**	**Spouse's Signature** (If applying for coverage)	**Date**
Dependent Signature*	**Date**	**Dependent Signature***	**Date**

*Required age 18 and over.

Primary Applicant Name: _____ **Agent Name:** __Insurance Now-770-396-9517