

**Use this checklist to make sure you
have included all that is required.**

- _____ 1. One application may be completed for an entire family
(applicant, spouse and dependent children)**
- _____ 2. Completed bank draft agreement
NOTE - 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, 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. All 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 (payable to Coventry) 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**



Underwritten by Coventry Health Care of Georgia, Inc.

FOR INTERNAL USE ONLY	
<input type="checkbox"/> ACH	<input type="checkbox"/> NON-ACH
<input type="checkbox"/> PDP	
Received Date: _____	

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 on page 6.

Check all that apply:

New Application Add a Dependent Plan Benefits Increase

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 POS

- \$3,000/ \$6,000
- \$5,000/ \$10,000

Fusion POS

- \$3,000
- \$5,000

Dental

* Dental is underwritten by Coventry Health and Life Insurance Company

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.

I elect to have an HSA opened through Health Equity

Optional Riders The below riders are optional. Please note that additional premium will 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: Day of CoventryOne Approval OR ____/____/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.

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:	
E-mail address (if we may correspond with you via e-mail)	<input type="checkbox"/> Check here to opt out of receiving your policy and other pertinent documents by e-mail			<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon	
Relationship	Occupation / Title			<input type="checkbox"/> Evening <input type="checkbox"/> Anytime (8am-8pm) () -	

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)	Social Security Number	Birthdate (mm/dd/yyyy)	Gender (M or F)	Height (ft. in.)	Weight (lbs.)	Tobacco use in the past 12 months? ¹	U.S. residency for past 6 months ²
1	Primary Applicant						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Spouse						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Home address (if different from Primary Applicant)						
3	Dependent Child						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Home address (if different from Primary Applicant)						
4	Additional Child						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Home address (if different from Primary Applicant)						
5	Additional Child						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Home address (if different from Primary Applicant)						
6	Additional Child						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		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	
<p>Has any individual applying for coverage had any health insurance coverage in the past two (2) years? If "Yes," list the applicants who are/were covered, the company who provided(s) coverage, along with the start and end dates of coverage. _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Medical Information The Medical Information 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 you may lose your coverage or other penalties may apply. 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 on page 5.		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
3 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 on page 5.		<input type="checkbox"/> Yes <input type="checkbox"/> No
4 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Check all that apply. In the past ten (10) 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, to be 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.</p>		
5 Cancer / Cyst / Tumor		
<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="checkbox"/> None
6 Respiratory System		
<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="checkbox"/> None
7 Cardiovascular and Circulatory System		
<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="checkbox"/> None
8 Digestive System		
<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="checkbox"/> None
9 Emotional or Mental Health		
<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="checkbox"/> None

10 Muscular or Skeletal System		
<input type="checkbox"/> Bursitis, tendonitis or gout <input type="checkbox"/> Disorder of the back, neck or spine <input type="checkbox"/> Connective tissue disorder, systemic lupus, rheumatoid arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Disorder of the knee, shoulder, hip or other joint <input type="checkbox"/> Osteoarthritis, osteoporosis or osteopenia	<input type="checkbox"/> Temporomandibular joint disorder (TMJ) <input type="checkbox"/> Fractures or broken bones <input type="checkbox"/> Prosthetic limbs or devices, or internal fixations (pins, plates, screws) <input type="checkbox"/> Any chiropractic treatments <input type="checkbox"/> Other	<input type="checkbox"/> None
11 Skin		
<input type="checkbox"/> Acne or rosacea <input type="checkbox"/> Eczema or psoriasis	<input type="checkbox"/> Abnormal or cancerous moles, melanoma <input type="checkbox"/> Other	<input type="checkbox"/> None
12 Eyes / Ears / Nose / Throat		
<input type="checkbox"/> Disease or injury of eye <input type="checkbox"/> Cataracts or glaucoma <input type="checkbox"/> Ear disorder, ear infections or tubes in ears <input type="checkbox"/> Hearing loss or cochlear implant	<input type="checkbox"/> Deviated septum or sinus infection <input type="checkbox"/> Disorder of the throat, tonsils or adenoids <input type="checkbox"/> Other	<input type="checkbox"/> None
13 Kidney or Urinary Tract		
<input type="checkbox"/> Bladder or urinary tract infection or disorder <input type="checkbox"/> Kidney infection or disorder	<input type="checkbox"/> Kidney or bladder stones <input type="checkbox"/> Other	<input type="checkbox"/> None
14 Female Reproductive System		
<input type="checkbox"/> Disorder of the breast or abnormal mammogram <input type="checkbox"/> Saline breast implants <input type="checkbox"/> Silicone breast implants <input type="checkbox"/> Abnormal Pap smear <input type="checkbox"/> Endometriosis, uterine fibroids or uterine prolapse	<input type="checkbox"/> Infertility or complications of pregnancy <input type="checkbox"/> Menopausal disorder <input type="checkbox"/> Menstrual disorder <input type="checkbox"/> Cervical, ovarian, uterine or vaginal disorder <input type="checkbox"/> Other	<input type="checkbox"/> None
15 Male Reproductive System		
<input type="checkbox"/> Infertility <input type="checkbox"/> Penile or testicular disorder	<input type="checkbox"/> Prostate disorder, elevated PSA, Prostatitis <input type="checkbox"/> Other	<input type="checkbox"/> None
16 Sexually Transmitted Diseases		
<input type="checkbox"/> Chlamydia <input type="checkbox"/> Genital warts <input type="checkbox"/> Genital herpes	<input type="checkbox"/> Human Papilloma Virus (HPV) <input type="checkbox"/> Gonorrhea or syphilis <input type="checkbox"/> Other	<input type="checkbox"/> None
17 Blood / Adrenal / Endocrine / Pituitary / Thyroid		
<input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Elevated blood sugar <input type="checkbox"/> Elevated cholesterol or triglycerides	<input type="checkbox"/> Endocrine, adrenal, or pituitary disorder <input type="checkbox"/> Weight disorder <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Other	<input type="checkbox"/> None
18 Brain or Nervous System		
<input type="checkbox"/> Concussion or head injury <input type="checkbox"/> Migraines or chronic headaches <input type="checkbox"/> Convulsions, seizures, epilepsy, fainting, tics or tremors	<input type="checkbox"/> Stroke, Transient Ischemic Attack (TIA) or paralysis <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Other	<input type="checkbox"/> None
19 Congenital or Development		
<input type="checkbox"/> Cleft palate or cleft lip <input type="checkbox"/> Developmental disorder or delay	<input type="checkbox"/> Mental retardation, autism, or Down's Syndrome <input type="checkbox"/> Other	<input type="checkbox"/> None
20 Alcohol / Drug		
<input type="checkbox"/> Alcohol abuse, dependency or alcoholism <input type="checkbox"/> Drug / substance abuse or dependency	<input type="checkbox"/> A citation or conviction for driving under the influence of alcohol or any drug / substance <input type="checkbox"/> Other	<input type="checkbox"/> None
21 Other Conditions		
<p>In the past ten (10) 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, 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?</p> <p>If "Yes," provide details in the Medical Details Section on page 5.</p>		<input type="checkbox"/> Yes <input type="checkbox"/> 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) 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 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

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 intentionally 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 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.

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 Signature¹	Date	Dependent Signature¹	Date

The below signatures must be completed if any child applying for health coverage (under the age of 18) has a Custodial Parent² 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 Signature²	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 (please print) Robert W. Ryals	Agent ID# (GA Insurance License #) 447986	Agent E-mail holly@insurance-now.com
Agency name Insurance Now	Agent / Agency phone 770-396-9517	

Agent Signature _____ **Date** _____
Robert W. Ryals

Premium Payment

Premium Payment Options Choose ONE (1) payment option. You must then complete the applicable sections regarding your account information.			
Initial payment by EFT, then:		Initial payment by check, then:	
<input type="checkbox"/> Monthly EFT (no administrative fee)		<input type="checkbox"/> Monthly billing (subject to Administrative Fee of \$5 each 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="checkbox"/> NEW Payroll Deduction Program (PDP)		<input type="checkbox"/> EXISTING Payroll Deduction Program (PDP)	
		PDP number: _____ PDP company 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 th day (or the next business day if a weekend/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 1 st of the month, the initial premium will be prorated based on your effective date.			
<input type="checkbox"/> Checking Account <input type="checkbox"/> 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="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____	
Account holder 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.			

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 Individual 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 CoventryOne at 1-866-364-5663 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 CoventryOne to collect the premium payment due between the 20th - 30th 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 CoventryOne to initiate automatic withdrawal and / or a billing cycle of applicable premium payments from your provided account or billing information. If your effective date is entered in the system after the third business day of the month, your first automatic withdrawal may include premium amounts for multiple months.

Account Holder Signature: _____	Date: _____
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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 CoventryOne 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 CoventryOne to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by CoventryOne for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for CoventryOne 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 CoventryOne 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 CoventryOne to use or disclose the information I provide in this Application (or that the CoventryOne 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 CoventryOne prior to the date such revocation is received by CoventryOne.

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.			