



**Coventry Health Care of Louisiana, Inc  
Group Enrollment Form**

1. Please print or type all necessary information. DO NOT WRITE IN SHADED AREAS.  2. Complete all items requested.	4. CURRENT MEMBERS: Check all items you wish to change in Section A. Complete Section B with your name and social security number. Fill in Sections C and D with updated information.	Group No.: _____ Effective Date: _____  <b>My benefit selection is:</b> <input type="checkbox"/> HMO PLAN <input type="checkbox"/> POS PLAN
3. NEW MEMBERS: Complete all items in Sections B, C, and D.	5. ALL MEMBERS: Complete pink copy & retain as Temporary I.D. Card for use until permanent card arrives.	

**Section A**

Check all that apply <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Telephone Change	Add Dependent(s) _____(date) <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Other	Cancel Dependent(s) only _____(date) <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Age Limit <input type="checkbox"/> Other	Cancel All Coverage _____(date) <input type="checkbox"/> Terminate Employment <input type="checkbox"/> Voluntary Withdrawal <input type="checkbox"/> Leave/Layoff <input type="checkbox"/> Out of Service Area Move <input type="checkbox"/> Other Continuation _____(date) Conversion _____(date)	Cobra _____(date) <input type="checkbox"/> Death <input type="checkbox"/> Termination <input type="checkbox"/> Reduction in work hours <input type="checkbox"/> Divorce/Separation <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Loss of Dependent Eligibility <input type="checkbox"/> Retirement	Reinstatement _____(date) <input type="checkbox"/> Return from layoff <input type="checkbox"/> Return from leave <input type="checkbox"/> Rehire <input type="checkbox"/> Disenrollment error <input type="checkbox"/> Other
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**Section B**

Last Name	First Name	Middle Initial	Social Security No.
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**Section C**

Address(Number, Street, Apartment)	City	State	Zip Code	Home Tel No
Date of Hire	Employer Name, Location			Work Tel No

**Section D**

Last Name, First Name, MI.	Member No.	Birthdate Mo/Day/Yr	Sex M/F	Social Security No.	Other Health Insurance Including Medicare
Subscriber	01				
Spouse	02				
Child					
Child					
Child					
Child					
Child					

**NOTICE – YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.**

**Please read the information on the back of this form and sign below.**

Employee Signature	Date	Employer Representative Signature (in Employee Absence)	Date
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I am applying for covered services for which I and my family dependents are eligible under the CHC Group Membership Agreement with my employer. I authorize my employer to deduct from my earnings the amount required.

All information on this form is true and correct to the best of my knowledge. 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 is guilty of a crime and may be subject to fines and confinement in prison.

I agree on behalf of myself and my family dependents to abide by the terms of the agreement describing my Coverage. I authorize any provider who provides services to me or my family dependents to Release to CHC and its participating providers any information or medical records relating to those services. I will complete and sign any documents necessary for CHC to assume my or my family

dependents' legal rights to collect from a third party any costs CHC incurred.

I also understand that the CHC Membership Agreement contains a provision which obligates me to follow a complaint procedure for any claim or disputes regarding Coverage.

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## TREATMENT OF GENETIC INFORMATION

### A. Non-Discrimination Policy

CHC will not take any of the actions listed below based on: (1) its knowledge of any Genetic Information concerning a Member or Member's family member; (2) its knowledge of a Member's or Member's family member's request for, or receipt of, genetic services; (3) its knowledge of a Member's or Member's family member's refusal to submit to a Genetic Test or to make available the results of a Genetic Test:

- Terminate, restrict, limit, or otherwise apply conditions to the coverage of the Member or family dependent of the Member under the Policy
- Cancel, or refuse to renew, the coverage of the Member or family dependent
- Deny coverage or exclude the Member or family dependent from coverage

- Impose a rider that excludes coverage for certain benefits or services
- Establish different premium rates or cost sharing for coverage
- Otherwise discriminate against an individual or family member in the provision of insurance.

The term "Genetic Information" as used above means all information about a person's genes, gene products, inherited characteristics, family history, or family pedigree.

The term "Genetic Test" as used above means any test for determining the presence or absence of Genetic Characteristics in a person. A "Genetic Characteristic" is any gene or chromosome, or alteration of a gene or chromosome, that is scientifically or medically believed to cause a disease, disorder, or syndrome, or to be associated with a statistically significant increased risk of development of a disease, disorder, or syndrome.

### B. Consent to Obtain Genetic Information

CHC must receive a Member's or family dependent's written and informed consent, or a written and informed consent of his or her representative, before obtaining genetic information from a Member or a family dependent or from a sample of his or her DNA.

CHC will provide a copy of the written consent to the Member. The written consent may be revoked or amended, in whole or in part, at any time. CHC will not treat a general authorization for a release of medical records or medical information as a written consent for the disclosure of genetic information. The authorization shall be invalid if it is used for any purpose other than the described purpose for which disclosure is made.

### C. Ownership of Genetic Information

A Member's or family dependent's genetic information is the property of the Member or family dependent and is not the property of CHC or its representatives.