SOUTHERN HEALTH SERVICES, INC.
A Coventry Health Care Plan

Statement of Health/Enrollment Form (Groups 2+)

COVENTRY
Health and Life Insurance Company

A EMPLOYER INFORMATION (To Be Completed by Employer)

Group No.	Group Name	Effective Date	Employer's Signature	Date

B SUBSCRIBER INFORMATION (To Be Completed by Employee)

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS: ☐ **None / Waive (Go to Section E)**

☐ HMO[1] _____ ☐ POS[1] _____ ☐ PPO[2] _____ ☐ HDHP[2] _____ ☐ Other _____

Type of Coverage: ☐ Employee ☐ Employee/Spouse ☐ Employee/Child ☐ Employee/Children ☐ Employee/Spouse/Children

If enrolling in an HMO plan, I acknowledge an out-of-network plan has been offered. ❑ **Yes** ❑ **No**

MARITAL STATUS
Please check one:
❑ Single/ Widowed
❑ Married
❑ Divorced

LAST NAME	FIRST NAME	MI	M/F	BIRTHDATE	HEIGHT	WEIGHT	SOCIAL SECURITY NO.

EMPLOYEE STATUS
Please check one:
❑ Active
❑ Retired
❑ COBRA

ADDRESS	PRIMARY CARE PHYSICIAN	PCP #

CITY	STATE	ZIP	HOME PHONE	WORK/DAY PHONE

C FAMILY MEMBERS TO BE COVERED

FULL NAME (Last, First, MI)	HEIGHT	WEIGHT	SEX	RELATIONSHIP	BIRTHDATE	OUT OF AREA STUDENT	SOCIAIL SECURITY #	PRIMARY CARE PHYSICIAN	PCP ID#	CURRENT PCP?
			M F	SPOUSE	/ /		- -			Y N
			M F		/ /	Y N	- -			Y N
			M F		/ /	Y N	- -			Y N
			M F		/ /	Y N	- -			Y N

D OTHER INSURANCE

WHEN coverage with Southern Health **BEGINS**, will you or any of your dependents have any other medical insurance coverage? ❑ Y ❑ N

Do you or your covered dependents have Medicare Coverage? ❑ Y ❑ N

E WAIVER **My employer has given me an opportunity to apply for group health coverage for myself and my dependents (if applicable)**

I waive coverage for the following plan(s): ❑ HMO or POS Plan[1] ❑ PPO or Satellite Plan[2]

Reason for decline: ❑ Other health insurance (list insurance company and policyholder name below) ❑ Other Reason:

I understand that even if I decline enrollment for myself or my dependents, spouse included, because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan if the other coverage is terminated, provided that I request enrollment within 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, or placement for adoption, I may be able to enroll myself and/or my dependents, provided I request enrollment within 31 days of such marriage, birth, adoption or placement for adoption.

X _____

Employee Signature (only if you are waiving coverage) Date:

Full Name of Employee (Please print) Date of Birth

[1] Underwritten by Southern Health Services, Inc. [2] Underwritten by Coventry Health and Life Insurance Company

F HEALTH INFORMATION (Please answer completely. Incomplete answers could delay the decision on your request for coverage.)

Please provide the health history of you and your family members who will be covered on this application. Please CIRCLE all applicable conditions and provide details for all YES answers in the appropriate section. Conditions include but are not limited to the following:

1) AIDS, HIV, alcohol or drug abuse, arthritis, birth defects, bleeding or clotting disorders, cancer, diabetes, disorder of the neck/back/spine, gastrointestinal disorders (ulcerative colitis, Crohn's, stomach ulcers), heart conditions, joint replacement, kidney (dialysis, failure, stones), liver (cirrhosis, Hepatitis B, C, or D), lung conditions, neurological disorders (cerebral palsy, multiple sclerosis, spinal cord injuries), organ transplant, stroke, tumors, vascular (blood vessel) disorders, or current tobacco use? ❑ Y ❑ N (**Circle all that apply** and give full details below)

2) During the last 24 months, have you or anyone who will be covered on this policy, had surgery or been admitted to any hospital or any other medical facility? ❑ Y ❑ N (Please give full details below)

3) Have you, or anyone to be covered on this policy, had any surgery or medical treatment discussed, planned or recommended? ❑ Y ❑ N (Please give full details below)

4) Is anyone currently pregnant? ❑ Y ❑ N If YES, Due Date: _____(Please give full details below)

5) Do you, or anyone who is to be covered on this policy, have any medical conditions which has not yet been disclosed? ❑ Y ❑ N (Please give full details below)

6) Is anyone currently taking any prescription medication? ❑ Y ❑ N (Please give full details below)

Please give full details for all Yes questions above. Additional pages may be used but must be signed and dated.

Question Number	Person's Name	Condition	Treatment (Month / Year)	Medications (oral, injectable, infusion, or inhaled)	Is further treatment needed? If yes, please explain:

G CONDITIONS OF ENROLLMENT

I hereby apply for membership in this Southern Health Services, Inc. (Southern Health)/Coventry Health and Life Insurance Company (CHLIC) Plan. I understand that my enrollment and benefits are in accordance with those described in the applicable Evidence of Coverage or Certificate of Insurance, and Group Agreement or Group Policy. If HMO or POS was elected on Page 1, I authorize (1) all health providers and insurers to furnish Southern Health, and (2) all health providers and Southern Health to furnish all insurers and health providers records concerning me or any member of my family for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. If PPO was elected on Page 1, I authorize (1) all health providers and insurers to furnish CHLIC, and (2) all health providers and CHLIC to furnish all insurers and health providers records concerning me or any member of my family for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative is entitled to receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certify that all the above information is correct. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through Southern Health/ CHLIC. For purposes of collecting information for an insurance policy application, policy reinstatement, or a request for change in policy benefits, this authorization shall remain valid for thirty months from the date the authorization is signed.

I represent on behalf of myself and any applicable dependents that to the best of my knowledge and belief all information submitted to Southern Health/CHLIC is complete and true, and I agree that this information shall be taken as the basis of the issuance of coverage for me and for each of the eligible dependents listed. I understand that Southern Health/CHLIC reserves the right to rescind coverage if any supplied information is materially inaccurate or incomplete. All claims relating to such fraud or misrepresentation and charges incurred after the termination will become my liability.

I understand and agree that Southern Health/CHLIC will rely upon the information and answers I have provided as the basis for establishing group premium rates applicable to such policy. I understand that I may be contacted by Southern Health/CHLIC to obtain additional follow-up information on myself and/or my dependents.

I HAVE READ AND AGREE TO THE CONDITIONS OF ENROLLMENT (Signature Required Below)

Employee Signature	Employee Printed Name	Date