Association Health Plan, Inc.

Diane Faulstich
7741 Becker Rd.
St. Louis, MO 63129
(314) 846-2583 • (314) 846-4329 (fax)

Attached is the application/change form for you to complete, sign and return to me.

Under separate e-mail you should have received your Health Connect quote, which compares rates and benefits of several plans. It is important to note that these quotes are based on ***preferred rates*** (optimal health). In the final analysis, the insurance companies may raise the rates quoted based on specific factors determined by the carrier's medical underwriting team. **You may be rated up for tobacco usage, prescription usage, recent surgeries and preexisting conditions.**

Please note...

CoventryOne -Group Health Plan (**GHP) will not process an application without banking information.** This is the only way they do billing.

Anthem BCBS does offer maternity coverage but there is an 18 month waiting period and you must select the maternity option on the application.

OUR PRIVACY COMMITMENT TO YOU:

We recognize, respect and will protect the personal privacy rights of all our customers. We understand that our customers entrust to us personal information. It is our policy to maintain the highest level of security regarding the collection of personal data.

After you have reviewed the enclosed, please give us a call and we will go over the specifics of each plan and address any questions.

Thank you for your interest and the opportunity to present this quote.

Sincerely,

Diane Faulstich
Agent

CoventryOne. Underwritten by Coventry Health and Life Insurance Company

Coventry Health Care of Missouri, Inc. ("Coventry Health Care")

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 and Authorization of Release Information Section.

Check all that apply:

☐ New Application ☐ Add a Dependent ☐ Guarantee Issue ☐ Plan Benefits Increase

CoventryOne Received Date: _____

Submit completed Application for Health Coverage to:
Coventry Health Care
550 Maryville Centre Drive, Ste 300
St. Louis, Missouri 63141-5818
Fax: 866-255-2763

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.

80% PPO Plans
☐ PPO 1000/80
☐ PPO 1500/80
☐ PPO 2000/80
☐ PPO 3000/80
☐ PPO 5000/80

100% PPO Plans
☐ PPO 1000/100
☐ PPO 1500/100
☐ PPO 2000/100
☐ PPO 3000/100
☐ PPO 5000/100

SJ Plans
☐ SJ 1500
☐ SJ 2500
☐ SJ 5000

Qualified High Deductible Plans (QHDHP)
☐ QHDHP 1500/100
☐ QHDHP 2500/100
☐ QHDHP 5000/100

Carelink from Coventry 80% PPO Plans
☐ PPO 1000/80
☐ PPO 2000/80
☐ PPO 3000/80
☐ PPO 5000/80

Carelink from Coventry SJ Plans
☐ SJ 1500
☐ SJ 2500
☐ SJ 5000

Carelink from Coventry Qualified High Deductible Plans (QHDHPs)
☐ QHDHP 2500/100
☐ QHDHP 5000/100

Network Selection If you have selected a Carelink from Coventry plan, you are required to choose a network below.

☐ Carelink from Coventry

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.

☐ **Autism Services Coverage Rider** – Applicants can elect coverage for Applied Behavioral Analysis (ABA) for treatment of autism. Benefit is limited to members up to nineteen (19) years of age. (376.1224 RSMo.) Additional premium may apply. MO residents only.

☐ **Maternity Coverage Rider (Only available for Carelink from Coventry plans)** – Female applicants can elect coverage for maternity services. Maternity benefits will begin 12 months after the effective date of maternity coverage.

Requested Effective Date Choose one (1) option only. 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
☐ ___ / ___ / _____ (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 and / or other selected options, 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 consent to receiving your policy and other pertinent documents by e-mail only				
Occupation / Title					

Audie Faulstich 314-846-4329
Agent Name: _____
MO DOI Approved on 12/15/11 17071

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 6 months?[2]	Primary Care Physician (PCP) Carelink from Coventry Only[3]
1	Primary Applicant SSN#					☐ Yes ☐ No	☐ Yes ☐ No	PCP Name PCP ID #
2	Spouse SSN#					☐ Yes ☐ No	☐ Yes ☐ No	PCP Name PCP ID #
		Home address (if different from Primary Applicant)						
3	Dependent Child SSN#					☐ Yes ☐ No	☐ Yes ☐ No	PCP Name PCP ID #
		Home address (if different from Primary Applicant)						
4	Dependent Child SSN#					☐ Yes ☐ No	☐ Yes ☐ No	PCP Name PCP ID #
		Home address (if different from Primary Applicant)						
5	Dependent Child SSN#					☐ Yes ☐ No	☐ Yes ☐ No	PCP Name PCP ID #
		Home address (if different from Primary Applicant)						
6	Dependent Child SSN#					☐ Yes ☐ No	☐ Yes ☐ No	PCP Name PCP ID #
		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 2 years. [3] For Carelink from Coventry products, the PCP must be within your provider network. 'Primary Care Physician (PCP)' refers to the provider that you would see first for any medical problem. A list of participating providers can be found at the health plan's website www.chcmissouri.com. Please note that choice of PCP is not guaranteed; however, should you be accepted for coverage, you can change your PCP at any time.

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

_____

2 Pre-Existing Condition Clause

If applying for PPO coverage, does any individual applying for coverage have proof of prior creditable coverage without a break in coverage of 63 days or more and would like to use it to credit any pre-existing condition limitation? ☐ Yes ☐ No
If "Yes," you must include a copy of the creditable coverage document(s) / Certificate of Creditable Coverage. You may be subject to a pre-existing condition exclusion until Coventry receives these documents.

3 HIPAA Guarantee Issue Coverage

If you have answered "Yes" to the above Pre-Existing Condition Credit question, you may be HIPAA eligible and may have the right to obtain certain individual health policies on a guaranteed issue basis and without application of any pre-existing condition exclusions or limitations. You must meet ALL of the following criteria:

- You must have had creditable coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage, other than coverage under a short-term health insurance policy, must have been under a group health plan, governmental plan, church plan or other health insurance coverage offered in connection with any such plan;
- Your coverage must not have been terminated because of fraud or failure to pay premiums;
- You must have been offered and elected COBRA or state continuation coverage and exhausted such coverage;
- You must not be eligible for a group health plan or Medicare and you must not have any other health insurance coverage.

☐ **Yes, I meet the above criteria and am applying for Guarantee Issue coverage.**

NOTE: If not all individuals applying for coverage meet the HIPAA requirements, those who are not HIPAA eligible must complete a separate Application for Health Coverage which will be reviewed through the regular underwriting process.

Audie Faulstich 314-846-4329

Agent Name: 17971

MO DOI Approved on 12/15/11

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 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 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 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 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	
In the past ten (10) years, has any individual applying for coverage ever or been diagnosed , received a positive test or received treatment for Human Immunodeficiency Virus (HIV) or 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 5 years, has any individual applying for coverage been diagnosed, treated or received advice from a health care professional for 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

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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 5 years, has any individual applying for coverage been diagnosed, treated or received advice from a health care professional for any other condition(s) not listed on this Application?
If "Yes," provide details in the Medical Details Section.

☐ Yes ☐ No

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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/yy)	Date of Recovery (mm/yy)	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 for any individual applying for coverage in the past 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/yy)	Date Discontinued (mm/yy)	Medication Name	Dosage and Frequency	Condition / Reason for taking

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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 unless applying for Guarantee Issue coverage. 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 including Guarantee Issue coverage. 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 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 knowlingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an Application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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	Agent ID#	Agent E-mail
Agency name	Agent / Agency phone	Name of General Agent
Payee (who is paid commissions) ☐ Agent ☐ Agency ☐ General Agent	Payee Tax ID#	
Agent Signature	**Date**	

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Premium Payment

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

☐ EFT

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

☐ **Monthly EFT**

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 monthly premiums will be withdrawn automatically on the 10th 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

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 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 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. You authorize Coventry to collect the premium payment due between the 10th of the month, including any unpaid fee amount. 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 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:**_____

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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 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 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.**

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

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

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 knowlingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an Application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to crimes and confinement in prison.

Primary Applicant's Signature	Date	Spouse's Signature (If applying for coverage)	Date
Dependent Signature* *Required age 18 and over.	Date	Dependent Signature*	Date

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