Application Submission Instructions

Please complete the attached application and send to Health Plan One either via fax or mail:

Health Plan One
1000 Bridgeport Ave. 4th FL
Shelton, CT 06484

Fax (Toll Free): 888.812.6887

Any questions? Please call Health Plan One at 1-877.567.5267. Thank you!

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

CoventryOne
Received Date: _____

Submit completed Application for Health Coverage to:
CHCLA, 3838 North Causeway Blvd., Suite 3350, Metairie, LA 70002 Or, by fax to: (866) 560-6328

Coventry Health Care of Louisiana, Inc. LA

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.

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.

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.

POS COPAY PLANS
- ☐ POS Copay 500
- ☐ POS Copay 750
- ☐ POS Copay 1000
- ☐ POS Copay 1500
- ☐ POS Copay 2500
- ☐ POS Copay 5000

POS COPAY VALUE PLANS
- ☐ POS Copay Value 500
- ☐ POS Copay Value 1000
- ☐ POS Copay Value 2500
- ☐ POS Copay Value 5000
- ☐ POS Copay Value 7500

Choose a pharmacy option for your POS Copay Value Plan
- ☐ Rx Plan A = $500 Rx deductible
- ☐ Rx Plan B = $1000 Rx deductible

HSA QUALIFIED HIGH-DEDUCTIBLE HEALTH PLANS
- ☐ HDHP $1700/0%
- ☐ HDHP $1700/20%
- ☐ HDHP $2500/0%
- ☐ HDHP $2500/20%
- ☐ HDHP $5000/0%
- ☐ HDHP $5000/20%
- ☐ HDHP Universal $2500/0%
- ☐ HDHP Universal $2500/20%

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

Requested Effective Date: 1st day of _____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	Parish	
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					

Primary Applicant Name: _____ Agent: _____

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 past 12 months?[1]	U.S. residency for past 6 months[2]
1	Primary Applicant						☐ Yes ☐ No	☐ Yes ☐ No
2	Spouse						☐ Yes ☐ No	☐ Yes ☐ No
		Home address (if different from Primary Applicant)						
3	Dependent Child						☐ Yes ☐ No	☐ Yes ☐ No
		Home address (if different from Primary Applicant)						
4	Additional Child						☐ Yes ☐ No	☐ Yes ☐ No
		Home address (if different from Primary Applicant)						
5	Additional Child						☐ Yes ☐ No	☐ Yes ☐ No
		Home address (if different from Primary Applicant)						
6	Additional Child						☐ Yes ☐ No	☐ Yes ☐ 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 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
2 Pre-Existing Condition Credit	
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? Using your creditable coverage credit may result in an adjustment to your quoted rate. 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.	☐ Yes ☐ No

Primary Applicant Name: _____ Agent Name: _____

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 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 2 years? If "Yes," provide details in the Medical Details section on page 5.	☐ 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 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.	☐ Yes ☐ 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?	☐ Yes ☐ No

Check all that apply. In the past 5 years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been 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 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.		
5 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
6 Respiratory System		
☐ Allergies or asthma ☐ Emphysema or chronic lung disease (COPD)	☐ Sleep apnea ☐ Other	☐ None
7 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
8 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
9 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

Primary Applicant Name: _____ Agent Name: _____

10 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
11 Skin		
☐ Acne or rosacea ☐ Eczema or psoriasis	☐ Abnormal or cancerous moles, melanoma ☐ Other	☐ None
12 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
13 Kidney or Urinary Tract		
☐ Bladder or urinary tract infection or disorder ☐ Kidney infection or disorder	☐ Kidney or bladder stones ☐ Other	☐ None
14 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
15 Male Reproductive System		
☐ Infertility ☐ Penile or testicular disorder	☐ Prostate disorder, elevated PSA, Prostatitis ☐ Other	☐ None
16 Sexually Transmitted Diseases		
☐ Chlamydia ☐ Genital warts ☐ Genital herpes	☐ Human Papilloma Virus (HPV) ☐ Gonorrhea or syphilis ☐ Other	☐ None
17 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
18 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
19 Congenital or Development		
☐ Cleft palate or cleft lip ☐ Developmental disorder or delay	☐ Mental retardation, autism, or Down's Syndrome ☐ Other	☐ None
20 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
21 Other Conditions		
In the past 5 years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been 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? If "Yes," provide details in the Medical Details Section on page 5.		☐ Yes ☐ No

Primary Applicant Name: _____ Agent Name: _____

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) 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

Primary Applicant Name: _____ Agent Name: _____

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. 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 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.

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 may be guilty of a crime and may be subject to fines and confinement in prison.

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 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
William C. Stapleton	20-4098658	sales@healthplanone.com
Agency name	**Agent / Agency phone**	**Name of General Agent**
HEALTHPLANONE, LLC	877-567-5267	
Payee (who is paid commissions) ☒ Agent ☐ Agency ☐ General Agent		**Payee Tax ID#** 20-4098658
Agent Signature		**Date**

Primary Applicant Name: _____ Agent Name: _____

Premium Payment

Premium Payment Choose ONE payment option. You must then complete the applicable sections regarding your account information.

☐ Monthly EFT (no administrative fee)

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 Coventry*One* Payroll Deduction Authorization Form with your Application.

☐ NEW Payroll Deduction Program (PDP)	☐ EXISTING Payroll Deduction Program (PDP) PDP number:_____ PDP name:_____

EFT (Electronic Funds Transfer) Information Complete this section if you have chosen to pay by EFT. The monthly premiums shown above will be withdrawn automatically from the bank account listed on the Application 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 your agent to complete a CoventryOne 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 Coventry Health Care of Louisiana at 1-866-364-5663 should your payment 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 Health Care of Louisiana to collect the premium payment due between the 20th and 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 Coventry Health Care of Louisiana 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 into the system after the third business day of the month, your first automatic withdrawal may include premium amounts for multiple months.

Account / Card Holder Signature:_____Date:_____

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

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 MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

_____	_____	_____	_____
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: _____