



Coventry Health Care of Iowa, Inc

Group Enrollment Form

1. Please print or type all necessary information. DO NOT WRITE IN SHADED AREAS.
2. Complete all items requested.
3. NEW MEMBERS: Complete all items in Sections B, C, D, and E.
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, D, and E with updated information.
5. ALL MEMBERS: Complete pink copy & retain as Temporary I.D. Card for use until permanent card arrives.

Group No.	Office Use Only Subscriber No.:	Effective Date:
Pharmacy Code:	Benefit Code:	

Section A

Check all that apply:

Name Change	_____	Add Dependent(s):	_____ (date)	Cancel Dependent(s) only	_____ (date)	Cancel All Coverage	_____ (date)	Cobra	_____ (date)	Reinstatement	_____ (date)
Address Change	_____	Marriage	_____	Marriage	_____	Terminate Employment	_____ (date)	Death	_____ (date)	Return from layoff	_____ (date)
Telephone Change	_____	Newborn	_____	Divorce	_____	Voluntary Withdrawal	_____ (date)	Termination	_____ (date)	Return from leave	_____ (date)
Change Primary	_____	Adoption	_____	Age Limit	_____	Leave/Layoff	_____ (date)	Reduction in work hours	_____ (date)	Relire	_____ (date)
Care Physician	_____	Legal Guardianship	_____	Other	_____	Out of Service Area Move	_____ (date)	Divorce/Separation	_____ (date)	Disenrollment error	_____ (date)
Pharmacy Change	_____	Other	_____	Continuation	_____ (date)	Other	_____ (date)	Medicare Eligible	_____ (date)	Other	_____ (date)
Card Correction	_____			Conversion	_____ (date)	Loss of Dependent Eligibility	_____ (date)	Retirement	_____ (date)		

Section B

Last Name _____ First Name _____ Middle Initial _____ Social Security # _____

Section C

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

Section D

Please indicate your pharmacy selection

Section E

Please select a Primary Care Physician for you and your dependents before submitting this application.

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

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.

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 the CHC to assume my or my family dependent's legal rights to collect from a third party any costs the CHC incurred.

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

Employee Signature _____ Date _____
 Employer Representative Signature (in Employee absence) _____ Date _____