

SECTION III — CONTINUED

CONTRACT INFORMATION

Coverage Begins:	Employee Eligibility:	Coverage Ends:	Dependent Age Limits:
<input type="checkbox"/> Date of hire 1st of month following: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 6 months <input type="checkbox"/> Other	<input type="checkbox"/> Min. 30 Hrs/Wk <input type="checkbox"/> Other	<input type="checkbox"/> End of month of termination <input type="checkbox"/> Date of termination <input type="checkbox"/> Other	<input type="checkbox"/> 19/24 <input type="checkbox"/> Other

Note: Any answers checked "Other" require Coventry Health Care of Kansas, Inc. approval.

Are all employees covered by Worker's Compensation? Yes No If No, explain:

For groups of 50+: Retirees to be Covered? Yes No If Yes, please complete the following:

<input type="checkbox"/> Eligible under age 65	Termination of Retiree Coverage:
<input type="checkbox"/> Eligible age 65 & older	<input type="checkbox"/> End of billing period at age 65
<input type="checkbox"/> Retiree's dependents eligible	<input type="checkbox"/> Other _____

INITIAL GROUP ENROLLMENT REQUIREMENTS

2. Eligibility requirements **will be** waived at enrollment (all full-time employees will enroll and waiting periods will be waived at initial enrollment).
 Eligibility requirements **will not be** waived at enrollment
 (all employees must satisfy the employee waiting period before enrolling).

3. Full-time employees are defined as those working a minimum of 30 or more hours per week.

4. Total number of employees (including those in the waiting period):
 Full-time employees _____
 Part-time, temporary or seasonal employees _____
 Total number of employees _____

5. Total number of employees eligible for coverage: _____

6. Total number of employees applying for coverage: _____

7. Number of employees terminated in the last 12 months: _____

8. Is the group required to provide COBRA coverage? Yes No If no, State Continuation? Yes No

9. Total number of COBRA or State Continuation continuants: _____

10. List all Employees/Dependents on COBRA or State Continuation (use separate sheet of paper, if necessary):

Name	Initial COBRA or State Continuation effective date	COBRA or State Continuation end date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. BANKRUPTCY

A) In the past 36 months, has the Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? Yes No

B) In the past 36 months, has any creditor filed or threatened to file a petition requesting the Company or any affiliated entity to be put into bankruptcy? Yes No

C) Give details to any question(s) with a Yes answer: _____

12. Workers' Compensation

Does the employer provide Workers' Compensation for all employees including the owners? Yes No
 If no, list employees not covered and indicate why not covered (use separate sheet of paper, if necessary)

Name	Reason not covered under Workers' Compensation
_____	_____
_____	_____
_____	_____

13. List the previous group health carriers for the last five years:

Name of carrier	Type of Coverage (PPO, HMO, POS, etc.)
_____	_____
_____	_____
_____	_____

SECTION III — CONTINUED

14. Are there any employees/dependents who are not actively performing their duties full-time due to a disabling illness, injury or pregnancy? Yes No

If yes, please list employee:

Name	Disability, injury or illness
_____	_____
_____	_____
_____	_____

15. Are there any employees/dependents who reside outside of the State of Kansas or the State of Missouri? Yes No

If yes, please list employee:

Name	Location (city, state, zip)
_____	_____
_____	_____
_____	_____

SECTION IV - HEALTH INFORMATION

Please complete the following questions to the best of your knowledge. This information is necessary to evaluate your group's application by Coventry Health Care of Kansas and/or Coventry Health and Life Insurance Co. In order to protect the individuals involved, do not disclose the name of any employee or dependent.

1. Are you aware of any employee, dependent or COBRA or State Continuation enrollee currently disabled? Yes No If yes, explain: _____

2. Are you aware of any employee, dependent or COBRA or State Continuation enrollee who incurred expenses of \$5,000 or more in the last 18 months?

Yes No If yes, explain: _____

3. Are you aware of any employee, dependent or COBRA or State Continuation enrollee who has been advised that necessary surgery or hospitalization is required (including pregnancy)? Yes No If yes, explain: _____

4. Are you aware of any employee, dependent or COBRA or State Continuation enrollee who has had an organ transplant such as kidney, liver, heart or lung?

Yes No If yes, explain: _____

5. Are you aware of any employee, dependent or COBRA or State Continuation enrollee who is currently being treated or diagnosed as having cancer, heart disease, lung disease, high blood pressure, diabetes or AIDS? Yes No If yes, explain: _____

6. Are you aware of any employee or dependent presently or soon to be on COBRA or State Continuation? Yes No If yes, explain: _____

7. Please list any known medical conditions within the last 5 years for which treatment was sought not described above: _____

SECTION V — BROKER INFORMATION

Broker Name	CHC of Kansas Broker Number
Department of Insurance License Number	Broker Commission Split
Agency Name	Broker Phone Number
Broker Address	Broker Fax Number
Broker Tax ID Number	CHC of Kansas Account Executive Name
Account Executive Code	CHC of Kansas Account Manager Name

SECTION VI — IMPORTANT READ CAREFULLY

I understand that this information may be verified by outside sources such as Equifax, or other investigative firms, which Coventry Health Care of Kansas, Inc. and/or Coventry Health and Life Insurance Company deems appropriate for finalizing its approval. Coventry Health Care of Kansas, Inc. and/or Coventry Health and Life Insurance Company reserves the right to retroactively adjust the rates provided if information, including medical information, subsequently received indicates this information was incomplete, inaccurate or a material misrepresentation was made in the application, and such information would have materially affected the rate calculation within a two-year period. Further, the proposal quotation may be invalidated or an enrolled group may be retroactively terminated and all premiums refunded if any material misrepresentations or omissions are found. After coverage has been in force for two years, no statement except fraudulent statements I make affect the policy.

I understand that Coventry Health Care of Kansas, Inc. and/or Coventry Health and Life Insurance Company are relying on the information provided herein and consider it material to the insurance risk assumed by Coventry Health Care of Kansas, Inc. and by Coventry Health and Life Insurance Company.

Renewal premiums for small groups are based on the following factors: 1) the medical inflation rate; 2) changes in coverage; 3) changes to the demographic characteristics of the group, 4) changes in the geographic area in which your business resides; and 5) the actual or expected claims costs for your group as permitted by law. Premiums are guaranteed for one year and will not be changed mid-year except for: 1) statutory changes mandating a mid-year benefit change; 2) a material change in the nature of your business or industry; or 3) any changes in benefits or enrollment criteria requested by you.

The Company certifies that the information provided on this document is complete and accurate. The Company shall notify Coventry Health Care of Kansas, Inc. and/or Coventry Health and Life Insurance Company promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly hired eligible employees or dependents and the termination or resignation date of any employees who are terminated by the employer. All coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been thoroughly explained to eligible employees.

This Application is subject to final approval by Coventry Health Care of Kansas, Inc. and/or Coventry Health and Life Insurance Company and shall be based upon all information supplied by the group, the requested benefits, and any other information obtained from outside sources which Coventry Health Care of Kansas, Inc. and/or Coventry Health and Life Insurance Company deems appropriate. This Application shall be attached to and shall become part of the Group Master Contract (the "GMC").

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.

Official Legal Company Name _____

dba if Applicable _____

Group Telephone Number _____

Owner/Officer/Partner Signature for Group _____

Signature

Date

Title

Location (City, State)

Broker _____

Print Name

Signature

Date

Location (City, State)

CHC of Kansas Authorized Signature _____

Signature

Date

Title