Coventry Health Care of Delaware, Inc.
2751 Centerville Road, Suite 400
Wilmington, DE 19808

[ ] NEW [ ]RENEWAL [ ] OPEN ACCESS

HMO GROUP #: _____
POS GROUP #: _____

SMALL GROUP APPLICATION FOR
STANDARD PACKAGE COST SHARING
(Maryland)

GROUP INFORMATION

Company Name: _____ Coverage Effective Date:_____

Street Address: _____ Anniversary Date:_____

City, State, Zip: _____ Open Enrollment: _____

County: _____ Contact Title: _____

Group Contact Name: _____ Contact Fax: _____

Contact Telephone: _____ Billing Contact: _____

Billing Address: _____ Nature of Business: _____

City, State, Zip: _____ SIC Code:_____

Previous Carrier:_____

COVERAGE FOR OTHER CLASSES OF EMPLOYEES:

[ ] I hereby elect to offer all Part-Time Employees coverage under the Standard Package Cost Sharing Plan. Part-Time Employee means an employee who has a normal work week of at least seventeen and one-half (17 ½) hours a week, but less than thirty (30) hours a week, and has been continuously employed for at least four (4) consecutive months.

[ ] I hereby elect to offer all Other Employees Coverage under the Standard Package Cost Sharing Plan. Other Employee means an employee who works for a Small Employer on a full-time basis with a normal work week of thirty (30) or more hours, and is covered under another public or private plan of health insurance or other health benefit arrangement. Other Employee does not include an individual who works on a temporary or substitute basis or for fewer than thirty (30) hours in a work week.

[ ] I do not wish to offer coverage to Part-Time Employees or Other Employees.

ELIGIBILITY WAITING PERIOD:

[ ] First of Month following _____ days. [ ]_____ days following Date of Hire.

[ ] Other:_____

TOTAL # OF ELIGIBLE EMPLOYEES:_____ Participation Requirement: 75% of Eligible Employees

TOTAL # OF WAIVERS: _____

TOTAL # OF APPLICATIONS:_____ Average Age of Applicants: _____

TERMINATION: The date of termination of coverage shall be

[ ] _____ the date of termination of employment.

[ ] _____ the last day of the month in which termination of employment occurs.

NOTE: The State of Maryland requires that an employer, labor union, association, or other entity to which a group contract has been issued to continue to pay the premium for an employee, member, or dependent under the contract until notice of termination of coverage has been received by the HMO.

COMPANY NAME: _____

BENEFITS: [ ] 2006 Comprehensive Standard ($30/40/1000/100) [ ] OA HSA' Standard 2700 (Rx 75% Coinsurance)
[ ] Coventry F ($30/40/250/100) [ ] Coventry E ($30/40/250/100) [ ] Coventry D ($20/30/250/100)
[ ] Coventry C ($10/20/250/100) [ ] Coventry B ($10/20/0/100) [ ] Coventry A ($10/20/0/50)
[ ] HMO HSA' 1200 (Rx $0/25/50+) [ ] HMO HSA' 1500 (Rx $0/25/50+) [ ] HMO HSA' 2000 (Rx $0/25/50+)

Open Access with Out-Of-Network Benefits:
[ ] Coventry POS E ($30/40/250/100) [ ] Coventry POS D ($20/30/250/100) [ ] Coventry POS C ($10/20/250/100)
[ ] Coventry POS B ($10/20/0/100 [ ] POS HSA' 1200 (Rx $0/25/50+) [ ] POS HSA' 1500 (Rx $0/25/50+)
[ ] POS HSA' 2000 (Rx $0/25/50+) [ ] POS 100/70 1050 HDHP (Rx 75% Coins) [ ] POS 100/60 1050 HDHP (Rx 75% Coins)

Prescription Rider:
[ ] $2500 Deductible; 75% Co-Insurance (ONLY ON 2006 Comprehensive Standard)
[ ] $0/25/50 $0 Deductible [ ] $0/25/50 $100 Deductible [ ] $0/25/50 $250 Deductible
[ ] $0/25/50 $500 Deductible [ ] $0/25/50 $1000 Deductible [ ] $0/25/50 $1500 Deductible
[ ] $10/20/30 $0 Deductible [ ] $15/20/30 $150 Deductible [ ] $15/25/50 $0 Deductible
[ ] $15/25/50 $100 Deductible [ ] $15/25/50 $150 Deductible [ ] $15/25/50 $250 Deductible
[ ] $20/35/60 $250 Deductible

DUAL OFFERING: [ ] No [ ] Yes

MONTHLY RATES:

Option 1:_____ Rates:

Emp $_____ Emp+Spouse $_____ Emp+Child(ren) $_____ Family $_____

Option 2:_____ Rates:

Emp $_____ Emp+Spouse $_____ Emp+Child(ren) $_____ Family $_____

MEDICARE WRAP RATES:
Emp $_____ Emp+Spouse $_____ Emp+Child(ren) $_____ Family $_____

POINT-OF-SERVICE OPTION: Under Maryland law, your employees may purchase a Point-of-Service option for health care services as an additional benefit. This Point-of-Service option allows your employees to obtain services from providers outside the HMO network under certain circumstances (described in the attached benefit description). You have the choice to pay this Point-of-Service option, pay a percentage of the cost of this option, or require your employees to pay for the entire cost of this option. Please indicate the employees who have chosen this Point-of-Service option by attaching their individual applications to this Application.

You have read and understand this disclosure statement and attachments and have provided notice of the availability of these additional benefits to your eligible employees.

APPLICATION: On behalf of the above named group, you hereby make application for a Group Master Contract to be issued by Coventry Health Care of Delaware, Inc. for the above listed benefits and the monthly premium rates shown. You understand that this application, if accepted by Coventry Health Care of Delaware, Inc., will form part of the Group Master Contract and is binding on both parties. On behalf of the above named group, you further agree that, by signing this Application the above named group will be bound by the terms and conditions contained herein as well as those in the Group Master Contract. You are authorized to commit to this contract arrangement on behalf of the above named company. If any required Premium payments are not received by Us by the end of the grace period, Covered Services for all enrolled Members shall be terminated on the last day of the grace period. **If you have any questions concerning the benefits and services that are provided or excluded under this agreement, please contact the Health Plan before signing this application.**

_____ _____
Signature Date Please print or type name and title

_____ _____
ACCEPTED: Coventry Health Care of Delaware, Inc. Date

BROKER INFORMATION (Please complete exactly as licensed)
Administrator Name (if applicable)_____

Selling Agent or Broker:_____ Agency Name: _____

Commissions Payable to: _____ Tax ID or SS#:_____

Address: _____ Telephone:_____

City, State, Zip: _____ Fax Number:_____