



**Coventry Health and Life Insurance Company
d.b.a. HealthAmerica**

PAYROLL DEDUCTION PROGRAM AUTHORIZATION FORM - INDIVIDUAL

EMPLOYEE / APPLICANT PORTION

As a convenience to me, I hereby request and authorize my employer (the "Company" identified below) to:

- a. deduct the amount of my HealthAmericaOne insurance premium from my compensation, by way of after-tax payroll deduction; and
- b. remit such monthly premium amount directly to Coventry Health and Life Insurance Company (CH&L).

I further request and authorize CH&L to accept premium directly from Company on my behalf.

I understand and agree:

1. HealthAmericaOne is not an employer-sponsored group health plan and that Company pays no portion of my premium.
2. Company is not acting as an agent of CH&L by performing any of the activities herein.
3. I am ultimately responsible for the payment of my HealthAmericaOne premium to CH&L. If Company fails to submit the required premium on my behalf, my HealthAmericaOne coverage will terminate in accordance with the terms set forth in my HealthAmericaOne policy, unless prior to termination I establish a personal payment arrangement directly with CH&L and pay such premium amount.
4. Company, CH&L or I may end this payroll deduction upon thirty-one (31) days advance written notice to the other parties. If this payroll deduction ends for any reason, I must provide personal checking account information to CH&L in advance of the termination of this payroll deduction program in order to retain my HealthAmericaOne policy. (Call the Customer Service number on the back of your ID card if you have questions.)
5. Participation in this HealthAmericaOne Payroll Deduction Program does not guarantee coverage and that coverage in HealthAmericaOne is based on the underwriting of my individual application.

Employee Name: _____
(please print)

Employee Address: _____
(please print)

Employee Signature : _____ **Date** _____

EMPLOYER / COMPANY PORTION

On behalf of the Company below, I hereby certify and agree that: **(a)** Company does not contribute any portion of, or reimburse employee for, the HealthAmericaOne premium for the individual named herein; **(b)** all premium payments are made from after-tax wages and Company does not take any tax deduction under Section 106, 125, 162 or 220 of the Internal Revenue Code; **(c)** HealthAmericaOne is not presented as an employer-sponsored group benefit plan to the employee; **(d)** Company will provide thirty-one (31) days advance notice to CH&L prior to terminating any premium payment; and **(e)** Company will indemnify CH&L for any claims related to Company actions that are contrary to the certifications contained herein.

Company Name: _____
(please print)

Company Address: _____
(please print)

Name and Title of Company Representative: _____
(please print)

Signature of Company Representative: _____ **Date:** _____
Fax form to: (866) 858-1521