



Coventry Health Care of Georgia, Inc.

CoventryOne® 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 CoventryOne insurance premium from my compensation, by way of after-tax payroll deduction; and
- b. remit such monthly premium amount directly to Coventry Health Care of Georgia, Inc. ("Coventry").

I further request and authorize Coventry to accept premium directly from Company on my behalf.

I understand and agree:

- 1. CoventryOne is not an employer-sponsored group health plan, and Company pays no portion of my premium.
- 2. Company is not acting as an agent of Coventry by performing any of the activities herein.
- 3. I am ultimately responsible for the payment of my CoventryOne premium to Coventry. If Company fails to submit the required premium on my behalf, my CoventryOne coverage will terminate in accordance with the terms set forth in my CoventryOne policy, unless prior to termination I establish a personal payment arrangement directly with Coventry and pay such premium amount.
- 4. Company, Coventry or I may end this payroll deduction upon thirty-one (31) days advance written notice to the other parties.
- 5. Participation in this CoventryOne Payroll Deduction Program does not guarantee coverage, and coverage in CoventryOne 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 CoventryOne 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) CoventryOne is not presented as an employer-sponsored group benefit plan to the employee; (d) Company will provide thirty-one (31) days advance notice to Coventry prior to terminating any premium payment; and (e) Company will indemnify Coventry 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)

Company Representative Signature: _____ Date: _____