

Employer Web Account Request Form

Employer Group Name:	
Employer Group Number:	

Check the box that coincides with your Health Plan:

- Altius Carelink CHC of DE CHC of GA Southern Health
 CHC of IA CHC of LA CHC of KS CHC of NE PersonalCare
 CHC of OK GHP WellPath Health America/Health Assurance

Employer Administrator Information

The designated Employer Administrator is responsible for creating and managing additional users according to the stipulations of the Electronic Commerce Agreement. *(All fields are Required)*

Name(First, MI, Last): _____

Title: _____

Work Address: _____

City / State / Zip: _____

Work Phone Number: _____

Email Address: _____

This is an initial request for a web account. Please establish an Employer Account with the associated Employer Administrator indicated above. I understand Coventry Health Care, Inc. must be notified of any changes to the Employer Administrator information.

By signing below, Group represents that it has read the Electronic Commerce Agreement and it agrees to the terms of the Electronic Commerce Agreement. For purposes of this Agreement, a signature sent by facsimile transmission shall have the full force and legal effect of an original signature.

The signature below must be that of the person authorized to contract for the Coventry benefit plan. (All fields are Required)

Signed: _____

Print Name: _____

Title: _____

Date: _____

Fax To Coventry CARE Team at 866-229-6403

Coventry Health Care, Inc.
CARE Team
PO Box 67103
Harrisburg, PA 17106-7103