Health Alliance℠
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IA LARGE GROUP APPLICATION/CHANGE FORM

SECTION 1: ENROLLMENT INFORMATION (to be completed by the Employer for all applicants)

GROUP INFORMATION:
Group Number: _____
Group Name: _____

SUB GROUP NUMBER:

PLAN TYPE: ☐ HMO ☐ PPO ☐ POS
PLAN NAME: _____

PLAN CODE:

EFFECTIVE DATE:

REASON FOR SUBMITTING APPLICATION: Mark all that apply.

☐ NEW HIRE
☐ NEW GROUP
☐ ADD DEPENDENT
☐ DEMOGRAPHIC CHANGE
☐ OPEN ENROLLMENT
☐ DELETE DEPENDENT
☐ LATE ENTRANT
☐ CONTRACT CHANGE (see below)
☐ SPECIAL ENROLLMENT (e.g., MARRIAGE, DEATH, BIRTH) – Reason for SEP/Date: _____
☐ TERMINATION (see below)
☐ TRANSFER (from another location)
☐ NON-BENEFIT ELIGIBLE TO BENEFIT ELIGIBLE
☐ ACTIVE
☐ RETIRED

POLICY/DEPENDENT CHANGE (CHECK ALL THAT APPLY):

☐ NAME CHANGE: FORMER NAME _____
☐ MARITAL STATUS CHANGE:
☐ MARRIED ☐ DIVORCED
☐ WIDOWED ☐ LEGAL SEPARATION
☐ DOMESTIC PARTNER
☐ COURT ORDER
☐ ADDRESS CHANGE
☐ PHONE CHANGE
☐ MEDICARE ELIGIBLE EMPLOYEE/ RETIREE-DEPENDENT TO POLICYHOLDER*

*Allows a Medicare eligible employee to enroll in a Health Alliance administered Medicare Advantage plan or Medicare Supplement plan and allows any active dependents to continue on the commercial group plan. Employee must complete a Medicare application separate from this application. Limited to specific counties. See your benefit administrator to verify eligibility.

CONTRACT CHANGE:

☐ ELECT CONTINUATION (COBRA)** (20+ EMPLOYEES)
☐ 18 mo. ☐ 29 mo. ☐ 36 mo.
☐ SPOUSAL CONTINUATION COVERAGE**
☐ DEPENDENT CONTINUATION COVERAGE**
☐ RE-ENROLL FROM LAY-OFF
☐ RE-ENROLL FROM LEAVE OF ABSENCE
☐ ELECT STATE CONTINUATION**

**More information on COBRA and Continuation coverage can be found in the member policy.

TERMINATION REASON:

☐ DECEASED _____/_____/_____
☐ SWITCHED HEALTH PLANS _____/_____/_____
☐ CANCEL CONTRACT
☐ LEFT EMPLOYMENT _____/_____/_____
☐ OTHER _____

Date of hire: _____/_____/_____

Benefits eligible date***: _____/_____/_____

Hours worked per week: _____

***Please refer to Eligibility Requirements of Group Enrollment Agreement for effective date of coverage. Premiums are due beginning with Benefits Eligible Date.

SECTION 2: GROUP APPLICATION/CHANGE INFORMATION (to be completed by applicant)

Last Name	First Name	M.I.	Birthdate	Sex	Social Security Number (required for IRS 1095B)
			/ /	☐ Male ☐ Female	

Street Address	City	State	ZIP Code	County

Primary Phone (area code + 7 digits)	Secondary Phone (area code + 7 digits)	Marital Status (circle one)	Prior Last Name
		Single Married Widowed Divorced	

Primary Care Provider (required for HMO or POS) _____

Are you an established patient? (circle one) Y N

What is your race? Select all that apply. (Optional)

☐ White
☐ Black or African American
☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian/Pacific ISL
☐ Other Pacific Islander
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Guamanian or Chamorro
☐ Samoan
☐ All Other Races/None of the Above
☐ Unknown
☐ Declined

Are you Hispanic, Latino/a, or Spanish origin? Select all the apply. (Optional)

☐ Hispanic, Latino/a or Spanish origin
☐ Non-Hipanic, Latino/a or Spanish origin
☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Unknown
☐ Declined

What is your preferred spoken language? (Optional)

☐ English
☐ Non-English
☐ Unknown
☐ Declined

What is your preferred written language? (Optional)

☐ English
☐ Non-English: _____
☐ Unknown
☐ Declined

DEPENDENT INFORMATION If any dependent child is over the age of 26 and an unmarried full-time student or disabled, you must attach documentation of a student's full-time status (e.g. class schedule, letter from college admissions office, etc.).

Name (last, first, MI)	Relationship	Sex	DOB	Social Security #	Name of Primary Care Provider	Established patient? Y/N	Resides with Employee? Y/N

If you are the legal guardian or stepparent, are you required by decree or court order to provide health coverage for that dependent? ☐ Yes ☐ No
If yes, attach a copy of that court decree.

OTHER COVERAGE

Are you or any dependent listed on this application currently covered by other group health insurance or plan? ☐ Yes ☐ No If Yes, please complete the following and indicate if double coverage is desired: ☐ Yes ☐ No

Name of Insured	Employer/Group	Group #/ Policy #	Insurance Co./Carrier	Subscriber #	Policy Coverage Dates	Family Members Covered
					_____ to _____	
					_____ to _____	

Do you receive any Veteran Affairs benefits? ☐ Yes ☐ No If yes, which VA facility_____

Medicare Coverage – If you or any dependent listed above will be covered by Medicare while enrolled in this health plan, please complete the following:

Enrollee Name	Medicare #	Part A Effective Date	Part B Effective Date	Is Medicare eligibility due to:
				☐ Kidney Failure ☐ Disability
				☐ Kidney Failure ☐ Disability

SECTION 3: WAIVE GROUP COVERAGE

☐ **I decline or refuse the medical coverage indicated below.**

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a qualifying event, it is within the next open enrollment period or I qualify as a late enrollee, if applicable.

Waiver of Coverage	Declining coverage due to existence of other coverage:	
I decline coverage for:	☐ Spouse's Employer's Plan	☐ Individual Plan
☐ Myself and all dependents	☐ Covered by Medicare	☐ Medicaid
☐ Spouse	☐ COBRA from prior employer	☐ VA Eligibility
☐ Dependent children	☐ Other _____	☐ Tri-Care
	☐ I (we) have no other coverage at this time	

Print Name _____ **Signature** _____ **Date** _____

SECTION 4: MEDICAL HISTORY (fraud or material misrepresentation of facts may be cause for rescission of coverage)

Employee Height (Ft/In)	Employee Weight (Lbs)	Spouse Height (Ft/In)	Spouse Weight (Lbs)
Dependent A Height (Ft/In)	Dependent A Weight (Lbs)	Dependent B Height (Ft/In)	Dependent B Weight (Lbs)

Have you or any dependent ever received treatment (including medication) or been diagnosed by a physician or mental health professional with:

Heart Disease ☐ Yes ☐ No	Allergy(ies) ☐ Yes ☐ No	Organ or other type transplant or implant ☐ Yes ☐ No
Stroke ☐ Yes ☐ No	Asthma ☐ Yes ☐ No	Breast Disorder ☐ Yes ☐ No
Circulatory Disorder ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Lupus ☐ Yes ☐ No
Chest Pain ☐ Yes ☐ No	Sinus or Nasal Disorder ☐ Yes ☐ No	AIDS, HIV or other Autoimmune Disease ☐ Yes ☐ No
Blood Pressure Disorder ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Any hospitalizations in the last 5 years ☐ Yes ☐ No
Elevated Cholesterol ☐ Yes ☐ No	Shortness of Breath ☐ Yes ☐ No	Any future surgeries planned ☐ Yes ☐ No
Anemia or Blood Disorder ☐ Yes ☐ No	Arthritis ☐ Yes ☐ No	Any drug or alcohol problems ☐ Yes ☐ No
Ulcers ☐ Yes ☐ No	Fibromyalgia ☐ Yes ☐ No	Any related treatment/rehab for drug or alcohol problems ☐ Yes ☐ No
Stomach Disorder ☐ Yes ☐ No	Back Disorder ☐ Yes ☐ No	In the last year, has anyone received medical treatment apart from routine physicals or immunizations? ☐ Yes ☐ No
Liver/Pancreas Disorder ☐ Yes ☐ No	Neck Disorder ☐ Yes ☐ No	Do you or any of your dependents take any medicine, drugs, pills or require shots? ☐ Yes ☐ No
Gallbladder Disorder ☐ Yes ☐ No	Joint Disorder ☐ Yes ☐ No	In the past 12 months, have you or any of your dependents used tobacco products? ☐ Yes ☐ No
Intestinal Disorder (Crohn's/Colitis) ☐ Yes ☐ No	Musculoskeletal Disorder ☐ Yes ☐ No	Are you, your spouse or any dependent currently pregnant? ☐ Yes ☐ No
Hernia ☐ Yes ☐ No	Skin Disorder ☐ Yes ☐ No	
Rectal Disorder ☐ Yes ☐ No	Chronic Fatigue Syndrome ☐ Yes ☐ No	
Menstrual Disorder ☐ Yes ☐ No	Epilepsy or Other Seizures ☐ Yes ☐ No	
Genital Disorder ☐ Yes ☐ No	Headaches or Migraines ☐ Yes ☐ No	
Sexual Dysfunction ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	
Pregnancy Complications ☐ Yes ☐ No	Cancer ☐ Yes ☐ No	
Infertility ☐ Yes ☐ No	Tumor ☐ Yes ☐ No	
Urinary Tract/Kidney/Bladder Disorder ☐ Yes ☐ No	Abnormal Growth ☐ Yes ☐ No	
Prostate Disorder ☐ Yes ☐ No	Carcinoma in Situ ☐ Yes ☐ No	
Diabetes ☐ Yes ☐ No	Eye Disorder ☐ Yes ☐ No	
Thyroid Disorder ☐ Yes ☐ No	Ear Disorder ☐ Yes ☐ No	
Adrenal Disorder ☐ Yes ☐ No	Attention Deficit Disorder ☐ Yes ☐ No	
Lymph-nodes Enlargement ☐ Yes ☐ No	Psychological Disorder ☐ Yes ☐ No	
Connective Tissue Disorder ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No	
	Eating Disorder ☐ Yes ☐ No	

If any of the above questions are answered "Yes," please indicate the following information (attach additional page if needed):

Patient Name	Illness or Diagnosis	Dates of Treatment	Type of Treatment	Physician's Name	Current Status/ Medication and Dosage

SECTION 5: AGREEMENT FOR COVERAGE AND SIGNATURE

CONSENT TO CONTACT

Please confirm how you would like to receive information from Health Alliance regarding your membership:

☐ U.S. Mail ☐ Text Message (provide phone number): _____ ☐ Email: _____

If you have selected text message or email, please provide your consent: I consent to receive an informational email or text about my Health Alliance membership. ☐ Yes ☐ No

I understand, agree, and represent that: I have read this document or it has been read to me. The answers provided within this entire application for coverage are, to the best of my knowledge and belief, true and complete. Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the insurance carrier's other rights and requirements.

I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud. If this application for coverage is accepted, coverage will be effective on the date specified by the insurance carrier on the certificate of coverage/certificate of insurance.

I hereby enroll for benefits as indicated in Section 2 of this application, for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice. I understand that the information I have provided in this application will be used by the insurance carrier and its affiliates to make decisions regarding eligibility, enrollment, underwriting, and premium risk rating.

I understand that protected health information described in this form may be used by, or disclosed by, organizations and persons who are not subject to federal and state privacy laws. I understand that the medical information provided also includes my spouse and/or dependents' information. I understand that I may be asked for authorization to disclose my medical, claim, or benefit records at a later time. I understand I may revoke this authorization at any time by giving advance written notice to Health Alliance. Revocation of this authorization form will not affect actions Health Alliance and others took in reliance on this form prior to written notice of revocation. I understand that I should retain a duplicate copy of this application for my own records. A photographic copy of this acknowledgment shall be as valid as the original.

This application will become part of the contract between Health Alliance and me.

I authorize the insurance carrier to electronically transmit the information contained herein. If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

Applicant Signature_____ **Date**_____