



Health Alliance Medical Plans, Inc.  
3310 Fields South Drive, Champaign, IL 61822

# IL SMALL GROUP APPLICATION/CHANGE FORM

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

<b>GROUP INFORMATION:</b> Group Number: _____ Group Name: _____		<b>SUB GROUP NUMBER:</b> _____	<b>PLAN TYPE:</b> <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <b>PLAN NAME:</b> _____
		<b>PLAN CODE:</b> _____	<b>EFFECTIVE DATE:</b> _____
<b>REASON FOR SUBMITTING APPLICATION: Mark all that apply.</b> (Attach Certificate of Creditable Coverage if applicable)			
<input type="checkbox"/> NEW HIRE <input type="checkbox"/> NEW GROUP <input type="checkbox"/> ADD DEPENDENT		<input type="checkbox"/> DEMOGRAPHIC CHANGE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> DELETE DEPENDENT <input type="checkbox"/> LATE ENTRANT	<input type="checkbox"/> CONTRACT CHANGE (see below) <input type="checkbox"/> SPECIAL ENROLLMENT (e.g., MARRIAGE, DEATH, BIRTH) – Reason for SEP/Date: _____
		<input type="checkbox"/> TERMINATION (see below) <input type="checkbox"/> TRANSFER (from another location) <input type="checkbox"/> NON-BENEFIT ELIGIBLE TO BENEFIT ELIGIBLE	<input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED
<b>POLICY/DEPENDENT CHANGE (CHECK ALL THAT APPLY):</b>		<b>CONTRACT CHANGE:</b>	<b>TERMINATION REASON:</b>
<input type="checkbox"/> NAME CHANGE: FORMER NAME _____ <input type="checkbox"/> MARITAL STATUS CHANGE: <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> COURT ORDER <input type="checkbox"/> WIDOWED <input type="checkbox"/> LEGAL SEPARATION <input type="checkbox"/> ADDRESS CHANGE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> PHONE CHANGE <input type="checkbox"/> MEDICARE ELIGIBLE EMPLOYEE/ RETIREE-DEPENDENT TO POLICYHOLDER*		<input type="checkbox"/> ELECT CONTINUATION (COBRA)** <input type="checkbox"/> RE-ENROLL FROM LAY-OFF (20+ EMPLOYEES) <input type="checkbox"/> RE-ENROLL FROM LEAVE <input type="checkbox"/> 18 mo. <input type="checkbox"/> 29 mo. <input type="checkbox"/> 36 mo. OF ABSENCE <input type="checkbox"/> SPOUSAL CONTINUATION <input type="checkbox"/> ELECT 12 MONTHS COVERAGE** STATE CONTINUATION** <input type="checkbox"/> DEPENDENT CONTINUATION COVERAGE** **More information on COBRA and Continuation Coverage can be found in the member policy.	<input type="checkbox"/> DECEASED _____/_____/_____ <input type="checkbox"/> SWITCHED HEALTH PLANS _____/_____/_____ <input type="checkbox"/> CANCEL CONTRACT <input type="checkbox"/> LEFT EMPLOYMENT _____/_____/_____ <input type="checkbox"/> OTHER _____
*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.		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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number (required for IRS 1095B)	
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)	
							Yes No	
What is your race? Select all that apply. (Optional)				Are you Hispanic, Latino/a, or Spanish origin? Select all the apply. (Optional)			What is your preferred spoken language? (Optional)	
<input type="checkbox"/> White <input type="checkbox"/> Japanese <input type="checkbox"/> Black or African American <input type="checkbox"/> Korean <input type="checkbox"/> Asian <input type="checkbox"/> Vietnamese <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Native Hawaiian/Pacific ISL <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> All Other Races/None of the Above <input type="checkbox"/> Asian Indian <input type="checkbox"/> Unknown <input type="checkbox"/> Chinese <input type="checkbox"/> Declined <input type="checkbox"/> Filipino				<input type="checkbox"/> Hispanic, Latino/a or Spanish origin <input type="checkbox"/> Non-Hispanic, Latino/a or Spanish origin <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Unknown <input type="checkbox"/> Declined			<input type="checkbox"/> English <input type="checkbox"/> Non-English <input type="checkbox"/> Unknown <input type="checkbox"/> Declined	
							What is your preferred written language? (Optional)	
							<input type="checkbox"/> English <input type="checkbox"/> Non-English: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Declined	

**DEPENDENT INFORMATION** If applicable, if any dependent is disabled or if any dependent child is aged 26–30 and honorably discharged from the military, you must attach documentation to verify status.

List all dependents covered. If adding or deleting a dependent, list only that dependent. Write name as it should appear on ID card.

Name (Last, First, M.I.)	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 the 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 (VA) 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 eligible due to:
				<input type="checkbox"/> Kidney Failure <input type="checkbox"/> Disability
				<input type="checkbox"/> Kidney Failure <input type="checkbox"/> 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.

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

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION 4: AGREEMENT FOR COVERAGE AND SIGNATURE (this form must be signed)**

**CONSENT TO CONTACT**

Please confirm if you would prefer to receive information electronically from Health Alliance regarding your membership?

If you consent, when we can, a text or email will be sent with a link to access your information, instead of mail.

I consent to receive information via email or text about my Health Alliance membership.  Yes  No

Text Message (provide phone number): \_\_\_\_\_  Email: \_\_\_\_\_

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 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 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 may be asked for authorization to disclose my medical, claim or benefit records at a later time. 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.

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.

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