Illinois Application for Individual & Family Health Insurance Coverage

Health Alliance™

For assistance in completing this application, please contact your agent, visit HealthAlliance.org or call 1-877-686-1168 Monday through Friday, 8 a.m.–5 p.m. CST. Mail your completed form to Health Alliance Medical Plans, ATTN: Individual Enrollment, 3310 Fields South Drive, Champaign, IL 61822. You may fax your completed application to 217-902-9755.

INSTRUCTIONS:

1. Any information you provide in this application is confidential.
2. The answers you provide in this application must be true and complete, to the best of your knowledge and belief. Do not leave any question unmarked.
3. An intentional misrepresentation may result in your policy being modified or terminated, or in claims being reduced or denied.
4. You should have the following information available for each person requesting coverage:
   - Social Security Number and date of birth (Newborn SSNs can be submitted later). SSNs are required for 1095B tax forms.
   - Information about any current insurance coverage
5. For purposes of this application, the term "dependent" refers to any child up to age 26 (or age 30 for military veterans) for whom you are requesting coverage, regardless of whether the child may be considered a dependent for tax or other purposes.
6. If applying during a Special Enrollment Period (outside the normal Open Enrollment Period), you will be required to provide supporting documentation to verify your qualifying event.
7. If you have an outstanding balance on a previous Health Alliance plan, any payment on your new plan will be applied to that outstanding balance first.

Primary Applicant Information

Name (Last)	(First)		(MI)
Residential Street Address:			Apt. #:
City:	State:	Zip:	County:
Mailing Address (If Different):			Apt. #:
City:	State:	Zip:	County:
Primary Phone Number: ( )	Secondary Phone Number: ( )		
Date of Birth: / /	Social Security Number:	Gender: ☐ Male ☐ Female	
Required Primary Care Physician (PCP): Name (Last) (First)		Are you an established patient? ☐ Yes ☐ No	

Please check all that apply: ☐ New Application ☐ Dependent Addition ☐ Plan Change

Select one from the following options:
☐ Open Enrollment
☐ SEP (Outside the Open Enrollment Period, you must have a Qualifying Event to apply for coverage. Please complete the "Attestation of Eligibility for an Enrollment Period" form and submit, along with this application and documentation verifying your Qualifying Event.)

_____

Requested Effective Date: _____
(Coverage not in force until Health Alliance approves your application and determines the effective date.)

Required In the last 6 months, has the policyholder or any dependent(s) used any tobacco product at least 4 times a week (such as cigarettes, snuff, chewing tobacco, or any nicotine substitution product)? ☐ Yes ☐ No
If yes, indicate who: ☐ Primary Applicant ☐ Spouse/Civil Union Spouse ☐ Dependent Children _____

Dependent Information

List all family members you wish to include under the policy. For more information regarding the available coverage, please check with Health Alliance.

Note: For purposes of this application, an "eligible military veteran" is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, and who received a release or discharge other than a dishonorable discharge.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Spouse/Civil Union Spouse Name (Last) (First) (MI)	
Social Security Number:	Date of Birth (mm/dd/yyyy):
Gender: ☐ Male ☐ Female	
Primary Care Physician (PCP) Name: (Last) (First)	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth (mm/dd/yyyy):
Social Security Number:	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Primary Care Physician (PCP) Name: (Last) (First)	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth (mm/dd/yyyy):
Social Security Number:	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Primary Care Physician (PCP) Name: (Last) (First)	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth (mm/dd/yyyy):
Social Security Number:	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Primary Care Physician (PCP) Name: (Last) (First)	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth (mm/dd/yyyy):
Social Security Number:	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Primary Care Physician (PCP) Name: (Last) (First)	

Plan Options: Please choose one.

☐ 2021 POS 1000 Elite Gold	☐ 2021 POS 7250 Elite Silver
☐ 2021 POS 2500 Elite Gold	☐ 2021 POS 6000 Elite Bronze
☐ 2021 POS 3000 Elite Silver	☐ 2021 POS 6500 Elite Bronze
☐ 2021 POS 4200 Elite Silver	☐ 2021 POS HSA 6900 Elite Bronze
☐ 2021 POS 5000 Elite Silver	☐ 2021 POS 8000 Elite Bronze
☐ 2021 POS 7000 Elite Silver	

Additional Coverage

Vision: ☐ VSP Vision Choice Plan $20 exam copay	Dental: ☐ Delta Dental PPO Bronze Plan
	☐ Delta Dental PPO Silver Plan
	☐ Delta Dental PPO Gold Plan

Current/Prior Coverage Information

For EACH person listed on this application, please indicate any current public health insurance coverage (for example, Medicare, HFS Medical Card, All Kids, Family Care, or other federal and state programs like the VA) or private health insurance. Each person applying for insurance must be listed below. If you currently do not have coverage, please indicate **NONE**.

Self Name (Last) (First) (MI)

Current Coverage: ☐ None ☐ Medicare ☐ Other Public ____________________________
☐ Employer Group ____________________________ ☐ Private (Insurer ____________________________)
☐ Individually Purchased ☐ VA (Facility ____________________________) ☐ Other (____)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________
Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Spouse/Civil Union Spouse Name (Last) (First) (MI)

Current Coverage: ☐ None ☐ Medicare ☐ Other Public ____________________________
☐ Employer Group ____________________________ ☐ Private (Insurer ____________________________)
☐ Individually Purchased ☐ VA (Facility ____________________________) ☐ Other (____)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________
Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Dependent Name (Last) (First) (MI)

Current Coverage: ☐ None ☐ Medicare ☐ Other Public ____________________________
☐ Employer Group ____________________________ ☐ Private (Insurer ____________________________)
☐ Individually Purchased ☐ VA (Facility ____________________________) ☐ Other (____)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________
Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Dependent Name (Last) (First) (MI)

Current Coverage: ☐ None ☐ Medicare ☐ Other Public ____________________________
☐ Employer Group ____________________________ ☐ Private (Insurer ____________________________)
☐ Individually Purchased ☐ VA (Facility ____________________________) ☐ Other (____)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________
Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Dependent Name (Last) (First) (MI)

Current Coverage: ☐ None ☐ Medicare ☐ Other Public ____________________________
☐ Employer Group ____________________________ ☐ Private (Insurer ____________________________)
☐ Individually Purchased ☐ VA (Facility ____________________________) ☐ Other (____)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________
Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Dependent Name (Last) (First) (MI)

Current Coverage: ☐ None ☐ Medicare ☐ Other Public ____________________________
☐ Employer Group ____________________________ ☐ Private (Insurer ____________________________)
☐ Individually Purchased ☐ VA (Facility ____________________________) ☐ Other (____)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________
Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

* If answering "Yes" please carefully read the following notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT & HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Health Alliance. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
3. It is recommended that you do not terminate your present contract until you are certain that your application for the new contract has been approved by Health Alliance.

Acknowledgement & Signature

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

❑ US Mail ❑ Text Message _____ ❑ 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

Signature – Adult applicants must sign this form below. Parent or guardian signature is required for applicants under the age of 18. By signing this form, you certify the following:

- 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, true and complete.
- Neither Health Alliance 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, this policy may be canceled retroactively, in which case any claim I submit may not be paid by Health Alliance. 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.

I understand that the information I have provided in this application will be used by Health Alliance and its affiliates to make decisions regarding eligibility and enrollment.

I understand that the information provided also includes my spouse/civil union 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 that I should retain a duplicate copy of this application for my own records.

I understand that no coverage shall be in force until approved by Health Alliance. If approved, coverage will be in force as of the effective date determined by Health Alliance.

I understand that this application will become part of the contract between Health Alliance and me.

I understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws.

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 took in reliance on this form prior to the written notice of revocation.

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.

I agree this Authorization shall be valid for two and one-half (2 ½) years from the latest signature date below.

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.

I HAVE READ AND CONSIDERED THE CONTENTS OF THIS FORM. BY SIGNING THIS FORM, I HEREBY AUTHORIZE THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ Date _____
Primary Applicant (or Authorized Legal Representative) Signature

_____ Date _____
Spouse/Civil Union Spouse Signature (ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

TO BE COMPLETED BY AGENT
Agent/Producer Information

I certify that:

- All answers provided in this application were completed by or provided by the applicant.
- I have reviewed this enrollment form to ensure that all required items have been completed.
- I am not aware of any information not disclosed on this enrollment form relating to the health, habits or reputation of any person listed on this enrollment form, which might have a bearing on the risk.

Agent/Broker

Agent Name:	ID#/Code:
Agency:	Phone: ( )
Email:	

Producer Signature: _____

Date Signed: _____
(A faxed signature shall be as valid as an original signature.)

Automatic Premium Payment Program

Sign up for automatic payments and enjoy knowing your payment is always on time. It's the easy way to pay. To get started, choose whether you'd like to pay using your credit card OR pay from your checking or savings account.

If you'd like to pay using your credit card, please visit HealthAlliance.org/Payment to set up your member account and payment information. You'll be able to set up automatic monthly payments using your Visa, Mastercard or Discover credit card, and you can choose any day between the 1st and the 12th of the month.

Note:

- If you're new member, watch for your welcome letter and member number in the mail. You'll need this to sign up for Your Health Alliance.
- You must be enrolled to set up your online member account.

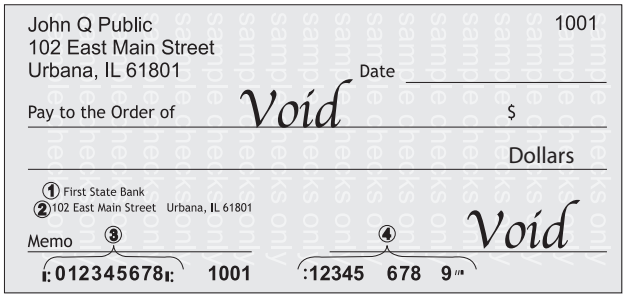
If you'd like to pay from your checking or savings account, fill out this form and send it (along with a voided check if paying from your checking account) to us using one of the following methods:

Fax: (217) 902-9784

Email: Autodraw@HealthAlliance.org

Mail: Attn: Autodraw
Health Alliance
3310 Fields South Drive
Champaign, IL 61822

Note: Your payment will happen on the first day of each month or on the closest business day.



Sample Voided Check
1. Name of financial institution **2**. Branch, City, State, ZIP
3. Routing number **4**. Account number

Automatic Premium Payment Authorization (please print)

Name (First, Middle Initial, Last)

_____

Social Security Number

___ ___

_____

Phone Number ( )

_____

Make this deduction from:

☐ **Checking** (Enclose voided check) ☐ **Savings**

See voided check sample for this information.

Financial Institution of Payor

Name _____

Branch _____

City _____ **State** _____ **ZIP** _____

Routing# _____

Account# _____

Would you like this to apply to your initial payment? If you select "No," or don't make a selection, you'll have to make an initial payment separately.

❑ **Yes*** ❑ **No**

* Premiums are pulled once the application is processed, not on the effective date.

I hereby authorize Health Alliance Medical Plans, Inc., and the financial institution named above to initiate monthly debit entries on the appropriate date and in the amount of the current premium for my plan and to initiate, if necessary, credit entries and adjustments for any debit entries in error to the account and financial institution indicated above. This authority is to remain in effect until Health Alliance has received written notification from me of its termination in such time as to afford Health Alliance and the financial institution a reasonable opportunity to act on it.

Signature _____ Date _____

If you have any questions, please call our Customer Service Department at the number listed on the back of your ID card.

Health Alliance™ Health Alliance NORTHWEST™