MEMBERSHIP AND RECORD CHANGE FORM

alliance health and life insurance company

(Please print or type. Prepare in duplicate.)

SOC. SECURITY NO.	SUBSCRIBER'S LAST NAME	FIRST NAME	INITIAL
ALLIANCE NUMBER	SUBSCRIBER'S CURRENT ADDRESS CHECK IF NEW ☐	CITY	STATE ZIP
PHONE NUMBER	GROUP NAME		GROUP NUMBER

REQUEST FOR MEMBERSHIP CHANGE

ADD MEMBERS TO POLICY (ADDITIONS)

	DATE OF EVENT MO.	DAY	YR.			SEX M	F	SOC. SECURITY NO.	DATE OF BIRT MO.	DAY	YI
☐ MARRIAGE TO				LAST NAME	FIRST NAME						
☐ BIRTH OF CHILD				LAST NAME	FIRST NAME						
☐ STEPCHILD				LAST NAME	FIRST NAME						
☐ CHILD BY LEGAL ADOPTION				LAST NAME	FIRST NAME						
☐ CHILD BY LEGAL GUARDIANSHIP (WARD)				LAST NAME	FIRST NAME						
☐ PRINCIPAL SUPPORT OF CHILD				LAST NAME	FIRST NAME						
☐ OTHER				LAST NAME	FIRST NAME						

ADDITIONAL INFORMATION

REMOVE MEMBERS FROM POLICY (DELETIONS)

	DATE OF EVENT MO.	DAY	YR.			SEX M	F	SOC. SECURITY NO.	ALLIANCE NUMBER
☐ DEATH OF DEPENDENT				LAST NAME	FIRST NAME				
☐ DIVORCE FROM				LAST NAME	FIRST NAME				
☐ MARRIAGE OF MINOR OR DEPENDENT				LAST NAME	FIRST NAME				
☐ OTHER				LAST NAME	FIRST NAME				

ADDITIONAL INFORMATION

AFTER THE CHANGES (ADDITIONS/DELETIONS) I WILL HAVE THE FOLLOWING MEMBERS LISTED ON MY POLICY

LAST NAME	FIRST NAME	LAST NAME	FIRST NAME	LAST NAME	FIRST NAME	LAST NAME	FIRST NAME
LAST NAME	FIRST NAME	LAST NAME	FIRST NAME	LAST NAME	FIRST NAME	LAST NAME	FIRST NAME

REQUEST FOR RECORD CHANGE

☐ CHANGE OF NAME — LAST NAME — FIRST NAME — MIDDLE INITIAL — ALLIANCE NUMBER

☐ DEATH OF SUBSCRIBER OCCURRED ON — MO. — DAY — YR.

☐ I HEREBY REQUEST CANCELLATION OF MY COVERAGE FOR MYSELF AND ALL DEPENDENTS

☐ SEND DUPLICATE I.D. CARDS

☐ SEND DUPLICATE COPIES OF ALLIANCE POLICY AND RIDERS

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO MY KNOWLEDGE AND BELIEF

SIGNATURE	MO.	DAY	YR.	WITNESS' SIGNATURE	MO.	DAY	YR.

THIS FORM SHOULD BE COMPLETED IN DUPLICATE TO REPORT ALL MEMBERSHIP AND RECORD CHANGES TO HEALTH ALLIANCE PLAN (IN KEEPING WITH REGULATIONS DETAILED ON THE SUBSCRIBER'S CERTIFICATE AND IN THE GROUP MEMBERSHIP OPERATING MANUAL). ONE COPY SHOULD BE SUBMITTED TO HAP, THE OTHER RETAINED EITHER IN THE GROUP MEMBERSHIP FILE OR BY THE SUBSCRIBER; WHICHEVER IS APPROPRIATE. THE FORM SHOULD BE SIGNED AND DATED WITHIN 30 DAYS OF THE EVENT REQUIRING THE MEMBERSHIP OR RECORD CHANGE. GROUP SUBSCRIBERS NOTE: THIS FORM MUST BE SUBMITTED WITH THE FIRST STATEMENT FOLLOWING THE EVENT REQUIRING THE CHANGE, OTHERWISE COVERAGE MAY BE DELAYED.

EXCEPT FOR THE SIGNATURE, PLEASE TYPE OR CLEARLY PRINT ALL ENTRIES. THE FOLLOWING GUIDELINES MAY BE USEFUL IN COMPLETING THIS FORM:

UNDER REQUEST FOR MEMBERSHIP CHANGE	
ADD MEMBERS TO CONTRACT	
MARRIAGE TO	REPORT THE ADDITION OF A WIFE/HUSBAND WITHIN 30 DAYS OF THE EVENT. YOU MAY COMPLETE AND SIGN THIS FORM 30 DAYS BEFORE THE MARRIAGE.
BIRTH OF CHILD	REPORT WITHIN 30 DAYS OF THE BIRTH DATE.
STEPCHILD	REPORT WITHIN 30 DAYS OF THE MARRIAGE. YOU MAY COMPLETE AND SIGN THIS FORM 30 DAYS BEFORE THE MARRIAGE.
CHILD BY LEGAL ADOPTION	REPORT WITHIN 30 DAYS OF THE DATE OF PETITION.
CHILD BY LEGAL GUARDIANSHIP/WARD	REPORT WITHIN 30 DAYS OF THE DATE OF PETITION.
PRINCIPAL SUPPORT OF CHILD	DO NOT CONFUSE WITH THE SUPPORT OF STEPCHILDREN. THIS CATEGORY INCLUDES DEPENDENTS SUCH AS A GRANDDAUGHTER, NEPHEW, ETC. GIVE THE DATE SUPPORT BEGAN. UNLESS OTHERWISE SPECIFIED, THE CHILD'S EFFECTIVE DATE WILL BE NO EARLIER THAN 90 DAYS AFTER SUPPORT FOR 6 MONTHS HAS BEEN ESTABLISHED.
OTHER	USE THIS AREA FOR REQUESTING THE ADDITION OF ANY OTHER ELIGIBLE DEPENDENT NOT LISTED ABOVE. THEN COMPLETE THE "ADDITIONAL INFORMATION" SECTION DESCRIBED BELOW AND INCLUDE SUPPORTING DOCUMENTATION.
ADDITIONAL INFORMATION	USE THIS AREA TO PROVIDE INFORMATION FOR AN "OTHER" DEPENDENT(S), OR WHEN ADDING MORE THAN ONE DEPENDENT. IDENTIFY THE EVENT, THE DATE THE EVENT OCCURED, AND GIVE THE LAST AND FIRST NAME, DATE OF BIRTH, AND SOCIAL SECURITY NUMBER OF THE "OTHER" DEPENDENT(S).
REMOVE MEMBERS FROM CONTRACT	
DEATH OF DEPENDENT	GIVE THE NAME OF THE DECEASED DEPENDENT AND DATE OF DEATH.
DIVORCE FROM	GIVE THE NAME OF THE DIVORCED SPOUSE AND DATE OF DIVORCE. UNDER "ADDITIONAL INFORMATION" INDICATE IF COVERAGE FOR THE CHILD(REN) IS TO BE CONTINUED ON THE SUBSCRIBER'S CONTRACT OR ON A CONTRACT ISSUED TO THE DIVORCED SPOUSE. BE SURE TO INCLUDE THE SOCIAL SECURITY NUMBER AND ADDRESS OF THE DIVORCED SPOUSE.
MARRIAGE OF MINOR OR DEPENDENT	GIVE THE DATE OF MARRIAGE AND (NEW) NAME OF THE FORMER MINOR OR DEPENDENT. BE SURE TO ENTER HIS/HER SOCIAL SECURITY NUMBER. UNDER "ADDITIONAL INFORMATION" GIVE THE NEW ADDRESS OF THE MARRIED MINOR OR DEPENDENT, AND THE NAME AND ADDRESS OF THE SPOUSE.
OTHER	USE THIS AREA FOR REQUESTING THE DELETION OF ANY OTHER DEPENDENT NOT COVERED ABOVE. THEN COMPLETE THE "ADDITIONAL INFORMATION" SECTION DESCRIBED BELOW.
MAIL GROUP CONVERSION CONTRACT TO THIS ADDRESS	GIVE THE ADDRESS OF ANY MEMBER THAT HAS BEEN REMOVED FROM YOUR COVERAGE FOR REASONS NOTED IN THIS SECTION AND TO WHOM A CONVERSION POLICY SHOULD BE SENT. IF THERE IS MORE THAN ONE MEMBER REMOVED, INDICATE THESE FORMER MEMBERS ALONG WITH THEIR NAMES, ADDRESSES, AND SOCIAL SECURITY NUMBERS UNDER "ADDITIONAL INFORMATION."
ADDITIONAL INFORMATION	USE THIS SPACE TO INCLUDE THE NAMES, ADDRESSES, SOCIAL SECURITY NUMBERS AND OTHER INFORMATION SPECIFICALLY REQUESTED UNDER OTHER AREAS OF THIS SECTION.
CHECK IF ANY MEMBERS ON THE CONTRACT ARE ELIGIBLE FOR COVERAGE UNDER PUBLIC ACT 275	STATE OF MICHIGAN PUBLIC ACT 275 REQUIRES CONTINUING COVERAGE FOR MENTALLY RETARDED OR PHYSICALLY HANDICAPPED DEPENDENTS BEYOND THE DATE THEY WOULD NORMALLY BE REMOVED FROM THEIR PARENTS CONTRACT. TO QUALIFY, SUCH DEPENDENTS MUST BE: (1) UNMARRIED; (2) INCAPABLE OF SELF-SUSTAINING EMPLOYMENT; (3) DISABLED BEFORE AGE 19; (4) DEPENDENT ON THE SUBSCRIBER FOR SUPPORT AND MAINTENANCE; AND (5) MUST HAVE PREVIOUS COVERAGE. A PHYSICIAN'S SWORN "CERTIFICATION OF DISABILITY MUST BE ATTACHED.

UNDER REQUEST FOR RECORD CHANGE	
ENROLL THE FOLLOWING MEMBERS IN THE HEALTH ALLIANCE PLAN COMPLEMENTARY COVERAGE	THIS HEAVILY BOXED AREA SHOULD BE COMPLETED ONLY BY THOSE MEMBERS ELIGIBLE FOR MEDICARE COVERAGE PARTS A AND B.
CHANGE OF NAME	ENTER THE NEW NAME. THE FORMER NAME SHOULD BE ENTERED ON THE TOP LINE OF THE FORM.
DEATH OF SUBSCRIBER OCCURED ON	GIVE THE DATE OF THE SUBSCRIBER'S DEATH. DO NOT CHECK THE CANCELLATION BOX. CHECK THE "BILL FAMILY" BOX IF CONTINUED COVERAGE IS DESIRED
I HEREBY REQUEST CANCELLATION OF MY COVERAGE...	WITH RESPECT TO GROUP MEMBERSHIP, DO NOT USE TO INDICATE TERMINATION OF EMPLOYMENT. TERMINATION SHOULD BE NOTED ON THE MONTHLY STATEMENT.
BILL FAMILY AT THE ABOVE ADDRESS	"ABOVE ADDRESS" REFERS TO "SUBSCRIBER'S CURRENT ADDRESS" AT THE TOP (SECOND LINE) OF THE FORM