AllianceHealth and Life INSURANCE COMPANY powered by hap

☐ PPO
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Employee Enrollment Application

1. **COMPANY NAME:** _____

COMPANY ADDRESS: _____

TO BE FILLED OUT BY EMPLOYER: **Group #** **Suffix #** **Effective Date of Coverage**

2. EMPLOYEE AND DEPENDENT DATA (All dependents must be listed)

Employee's Last Name	First	Middle Initial	❑ Male ❑ Female
Home Address	City	State Zip	Phone Home ( ) Phone Work ( )
Division/Employee No.		Date of Hire	Occupation

IMPORTANT — List family members for which you are applying. Legal first name and middle initial only – Last name if it is different from yours.

NAME AND INITIAL	SOCIAL SECURITY NUMBER	BIRTH DATE	SEX	RELATIONSHIP CODES* (See codes below)
EMPLOYEE				
SPOUSE				
DEPENDENTS				

RELATIONSHIP CODES:
SP – Spouse LG – Legal Guardianship HD- Handicapped Dependent Child DC – Dependent Child YA – Young Adult (19-23) or (19-25)

Does anyone listed above have other health care coverage? If so, complete the following:
❑ SELF ❑ SPOUSE ❑ DEPENDENT
Type of Coverage
❑ BCBS
❑ OTHER _____
❑ MEDICARE No.: _____
Effective Date for PART A: _____
Effective Date for PART B: _____

Have you or any of your dependents previously been a Health Alliance Plan member?
❑ YES ❑ NO
NAME: _____
FORMER HAP#: _____

Have you or any of your dependents previously been an Alliance Health and Life member?
❑ YES ❑ NO
NAME: _____
FORMER ALLIANCE #: _____

Are you to provide medical coverage for a child(ren) listed above according to a qualified medical child support order (QMCSO)?
❑ YES ❑ NO
(IF YES, PLEASE ATTACH DOCUMENT)

Does a qualified medical child support order (QMCSO) exist for any dependent child(ren) listed on this application?
❑ YES ❑ NO
(IF YES, PLEASE ATTACH DOCUMENT)

▶▶ FORM CONTINUED ON REVERSE! ▶▶

3. MUST be signed below by persons applying for coverage. NOTE: this application remains valid for 45 days from the date signed.

MISSTATEMENT

I HEREBY APPLY for the group benefits for which I am eligible under the policy provided by Alliance Health and Life Insurance Company. I understand and agree that all statements and answers made in this application are true, complete and correctly recorded and constitute the sole basis for the issuance of the benefits applied for in this application. I understand that the requested coverage is subject to approval by Alliance.

RECISION

I FURTHER UNDERSTAND that failure to disclose all information or any misstatement of information as requested in Parts 1, 2, 3 and 4 may be the basis for cancellation of coverage during the first twenty-four (24) months of enrollment.

PRE-CERTIFICATION REQUIREMENTS

I UNDERSTAND that this policy has certain pre-certification requirements which are explained in detail in each employee's certificate booklet. Failure to obtain the required pre-certification will result in reduced benefits.

INFORMATION RELEASE

I AUTHORIZE my employer to make the necessary payroll deductions, if any are required. I CERTIFY I understand the above information to be full, complete and accurate. I AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, or other organization, institution or person, including Alliance's Health Care Center, that has any records of knowledge of my, or my family's health to give that information to insurance companies, including their reinsurers. A photographic copy of this authorization shall be considered to be valid as the original.

X _____ _____/_____/_____

Employee's Signature DATE (Month Day Year)

4. Group Health Coverage Waiver (Complete ONLY if you and/or your dependents DO NOT WANT health benefits).

"I hereby certify that the benefits of my employer's Group Benefit Program have been explained to me. I understand the benefits and have been given the opportunity to participate in the program. I voluntarily and intentionally have decided to waive benefits and not participate in the portion(s) of the group insurance benefit plan check below by me. Further, I acknowledge and understand that if, in the future, I and/or my dependents desire to participate and enroll in the program, then it will be necessary for me and/or my dependents to meet any and all eligibility requirements then in effect. If I or my dependents wish to enroll with an effective date outside my groups open enrollment period, we will have to present evidence of insurability. This includes taking and passing a physical examination at my expense."

GROUP HEALTH WAIVER

- ❑ For myself and my dependent(s), if any or
- ❑ For my spouse only
- ❑ For my children only
- ❑ For my dependent(s) only
- ❑ Other coverage _____

X _____ _____/_____/_____

Employee's Signature **(sign only if waiving benefits)** DATE (Month Day Year)

Group #: _____ Certificate#: _____ Effective Date: _____

Medical Plan #:

❑ Single ❑ Spouse ❑ Child ❑ Family ❑ Children ❑ Deductible $_____

Transfer of Coverage

❑ Single ❑ Spouse ❑ Child ❑ Family ❑ Children ❑ Deductible $_____