HMO
Enrollment Application Card

Enrolling for: ❑ HMO ❑ POS ❑ Other

Last Name	Legal First and Middle Initial	Social Security Number	Phone ( )	Birth Date	Male ❑ Female ❑	Group Number & Suffix

Address	Apt.	City	State	Zip	County	E-mail

Name of Employer	Date of Hire	Department Code	Effective Date

Personal Care Physician	PCP Code	HAP Number

Important - List Family Members you are covering. Legal First Name and Middle Initial Only • Last Name if different from yours **NOTE: Grey Shaded Areas For Internal Use Only**

Name and Initial	Social Security Number	Birth Date	Sex	Relationship	Personal Care Physician	PCP Code	HAP Number
Spouse							
Dependents							

Duplicate Coverage

Are you, your spouse or dependents covered under any other group medical, pharmacy, vision plan (including your spouse's employer) or Medicare?
Check One ❑ Yes ❑ No

Are any of your dependents included in a divorce decree with health care coverage?
Check One ❑ Yes ❑ No

Court Ordered Parent's Name and Social Security Number_____
(Attach a copy of the order if not already on file).

If you answered yes to either of the above questions, please fill in the information below. If applicable, please note which dependent is covered under the court order above.

	Name of Employer (Include Address and Phone)	Name of Insurance Carrier (Include Address and Phone)	Policy Number(s)	Person(s) Covered
MEDICAL				
PHARMACY				
VISION				

Medicare: Complete the following section for yourself and each family member covered under Medicare.

Name	Medicare Claim Number	Part A Effective Date	Part B Effective Date

Have you or any of your dependents previously been a HAP member?

❑ Yes ❑ No

Fomer Name _____

Former HAP Number (if known)_____

Spouse's Maiden Name _____

Race/Ethnicity:

_____

Primary Language:

_____

Relationship Codes

SP - Spouse
DC - Dependent Child
LG - Legal Guardianship
HD - Handicapped Dependent Child
SD - Sponsored Dependent (No Medicare)
DP - Domestic Partner
SR - Senior Rider (26 Years or Older With Medicare)

I have read and agree to the terms on the reverse side

Sign Here _____ **Date**_____

Processor

Date

Please Complete Fully

HMO Enrollment Application Contract

It is my responsibility to read the HMO Subscriber Contract from Health Alliance Plan (HAP) when I receive it to know which rules I must follow for coverage with this plan.

I apply on behalf of myself and eligible family members, as listed, for enrollment in and for the health services provided to members of Health Alliance Plan, which is now available through my employer's insurance program. I hereby revoke all previous enrollment applications executed by me for hospital and medical expense coverage as made available by my employer.

I may enroll my child(ren) who are either my own, legally adopted or those of my spouse by a previous marriage as defined below.

I may list dependent children to age 26. Such children can be covered through December 31 of the year in which they turn 26.

I understand that unmarried children, disabled before age 26 are considered to be dependent children and covered to any age. Such children must be incapable of self-sustaining employment by reason of mental or physical handicap, and must have previous coverage. I understand that I must provide medical documentation verifying the disability.

I understand that I am responsible for providing my dependents Social Security Numbers.

I understand that my dependents and I will not be eligible for hospital admissions, doctor's services and other covered services until the effective date of my membership as determined by Health Alliance Plan and my employer.

I authorize persons rendering medical or hospital care and related services (including hospitals and medical groups contracting with Health Alliance Plan) to provide records and other information concerning such care or services to Health Alliance Plan.

Whenever the full subscription rate is not paid by my employer, I authorize my employer to periodically deduct in advance from my wages and to remit to Health Alliance Plan, the amount necessary to pay the periodic rate.

As the subscriber I may cancel this application within 72 hours of signing by sending written notice to Health Alliance Plan or my employer.