Health Alliance Individual
Plan Change Form

This form is NOT for Marketplace plan members. If you are a Marketplace plan member, please go to healthcare.gov to make changes to your plan.

If you have any questions, please contact your agent, or call 1-866-247-3296, Monday through Friday, 8 a.m.–5 p.m. CST.

After completing the form, please return it by using one of the options below:

Fax
217-902-9755, ATTN: Health Alliance Individual Enrollment

Mail
Health Alliance Medical Plans
ATTN: Individual Enrollment
3310 Fields South Drive
Champaign, IL 61822

Outside the open enrollment period, you must have a qualifying event to apply for coverage and submit the Special Enrollment Period (SEP) attestation form with your application. SEP attestation forms can be found on HealthAlliance.org. 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. If you are adding dependents, please submit the "Illinois Application for Individual and Family Health Insurance Coverage." You can find that at HealthAlliance.org.

Section A: Member Information

_____
Policyholder Name (Required)

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Member Number (Required)

_____
Dependent Name

_____
Dependent Name

_____
Dependent Name

_____
Dependent Name

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 _____

Section B: Plan Selection

Please choose one plan.

POS Plan Name	
2021 POS 1000 Elite Gold	❑
2021 POS 2500 Elite Gold	❑
2021 POS 3000 Elite Silver	❑
2021 POS 4200 Elite Silver	❑
2021 POS 5000 Elite Silver	❑
2021 POS 7000 Elite Silver	❑
2021 POS 7250 Elite Silver	❑
2021 POS 6000 Elite Bronze	❑
2021 POS 6500 Elite Bronze	❑
2021 POS HSA 6900 Elite Bronze	❑
2021 POS 8000 Elite Bronze (only on exchange)	❑

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	❑

Section C: Signature and Date

Policyholder Signature _____ Signature Date _____

☐ I agree that the typed name above shall be treated as a valid signature for all purposes of this form.

↓ FOR OFFICE AND BROKER USE ONLY ↓

Agent Name: _____

Agency: _____

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.

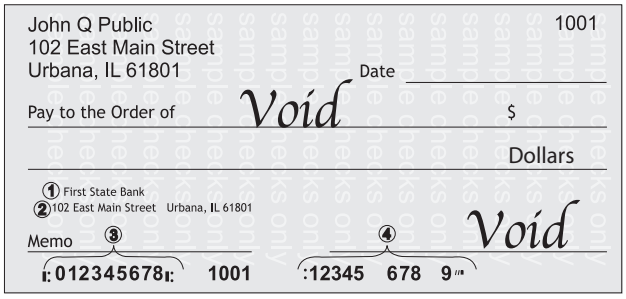
If you'd like to pay from your checking or savings account, fill out this form and send it (along with a voided check if paying from your checking account) to us using one of the following methods:

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™