Health Alliance NORTHWEST™

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a health plan during the Open Enrollment Period. There are exceptions that may allow you to enroll in a health plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for a special enrollment period. You are now required to provide documentation to verify your SEP. If we later determine that this information is incorrect, you may be disenrolled. The "Date of Event" is the date of the qualifying event (marriage, divorce, birth of a child, loss of coverage, etc.) that may qualify you for special enrollment.

❐ If you and/or your dependents involuntarily lose coverage due to loss of eligibility, which may include loss of coverage resulting from termination of employment, a reduction in the number of work hours or a termination of employer contributions, being released from incarceration or you receive a notice of the loss of minimum essential coverage, you and your eligible dependents may enroll in the plan. The "Date of Event" is the last full day of coverage with previous carrier.
Date of Event: __________

❐ If you acquire a new dependent through marriage or a civil union partnership you may enroll yourself and/or your new Legal Spouse and eligible Dependents in the Plan.
Date of Event: __________

❐ If you acquire a new dependent through birth, adoption or placement of a child pending legal adoption, you may enroll yourself, your eligible legal spouse, the newborn or newly adopted child and any other eligible dependent children not currently enrolled in the plan.
Date of Event: __________

❐ If you gain a new dependent under court order, you may enroll yourself, your legal spouse, the new dependent or any other eligible dependent not currently enrolled in the plan.
Date of Event: __________

❐ If you or your eligible dependents enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation or inaction of an officer, employee or agent of the Health Insurance Marketplace for Health and Human Services (HHS), or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or inaction. If you or your eligible dependent's enrollment in a health plan is unintentional, inadvertent, or erroneous resulting from action by a non-Exchange entity.
Date of Event: __________

❐ If you or your eligible dependents adequately demonstrate to the health insurance marketplace that a qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
Date of Event: __________

❐ If you or a qualified individual becomes newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost sharing reductions.
Date of Event: __________

❐ If a qualified individual or enrollee, or his or her dependent gains access to new qualified health plans as a result of a permanent move.
Date of Event: __________

❐ If you experience a loss of a dependent or dependent status through divorce or legal separation.
Date of Event: __________

❐ If a qualified individual or his or her dependent was not previously a citizen, national or lawfully present and gains such status.
Date of Event: __________

❐ If you experience a loss of a dependent or dependent status through death.
Date of Event: __________

____ ______________________

Sign Date

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

Health Alliance Northwest Individual

Plan Change Form

If you have any questions, please contact your agent, or call 877-750-3517, Monday through Friday, 8 a.m.–5 p.m. CST

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

Email
individualenrollment@healthalliance.org
Fax
217-902-9755, ATTN: Health Alliance Northwest Individual Enrollment

Mail
Health Alliance Northwest
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. You are asked to verify your qualifying event.

Section A: Member Information

____
Policyholder Name (Required)

____
Dependent Name

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Member Number (Required)

____
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/Domestic Partner
❑ Dependent Children ____

Section B: Plan Selection

Please choose one plan.

Summit Plan Name	
Summit 4500 Silver	❑
Summit 5500 Bronze	❑
Summit HSA 6500 Bronze	❑

POS Plan Name	
POS 2000 Gold	❑

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: ______________________________