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Urbana, Illinois 61801
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GROUP APPLICATION/CHANGE FORM

CLINIC NO. (if applicable)	GROUP NO.	SUBSCRIBER NO.
SUB GROUP #	PLAN CODE	EFFECTIVE DATE

SECTION 1: ENROLLMENT INFORMATION (to be completed by the Employer for all applicants)

GROUP INFORMATION:
Group Number: ______
Group Name: ______

PLAN TYPE: ☐ HMO ☐ PPO ☐ POS ☐ Other ______

REASON FOR SUBMITTING APPLICATION: Mark only one. (Attach Certificate of Creditable Coverage if applicable)

☐ NON-BENEFIT ELIGIBLE TO BENEFIT ELIGIBLE (part-time to full-time)
☐ LATE ENROLLMENT
☐ OPEN ENROLLMENT
☐ NEW HIRE
☐ NEW GROUP
☐ SPECIAL ENROLLMENT (Marriage, Divorce, Birth, Death or Adoption)
☐ ACTIVE
☐ RETIRED

POLICYHOLDER/DEPENDENT CHANGE (CHECK ALL THAT APPLY):

☐ ADD DEPENDENT
☐ DELETE DEPENDENT
☐ MARITAL STATUS CHANGE:
  ☐ MARRIED ☐ DIVORCED
  ☐ WIDOWED ☐ LEGAL SEPARATION
  ☐ DOMESTIC PARTNER
☐ LOSS OF COVERAGE:
  DATE OF LOSS ____/____/_____
☐ NAME CHANGE: FORMER NAME ______
☐ ADDRESS CHANGE
☐ PHONE CHANGE

REASON FOR CHANGE:

CONTINUATION ELECTED
☐ COBRA
☐ STATE CONTINUATION
☐ SPOUSAL COVERAGE (IL ONLY)
☐ DEPENDENT COVERAGE (IL ONLY)
☐ IMRF _____/_____/______

☐ RE-ENROLL FROM LAY-OFF
☐ RE-ENROLL FROM LEAVE OF ABSENCE
☐ MOVED OUT OF SERVICE AREA
☐ LEFT EMPLOYMENT
Date of Termination: _____/_____/______

☐ DECEASED
☐ SWITCHED HEALTH PLANS
☐ CANCEL COVERAGE
☐ OTHER ______

Date of hire/event: ______/______/_______

Benefits eligible date*: ______/______/_______

*Please refer to Eligibility Requirements of Group Enrollment Agreement for effective date of coverage. Premiums are due beginning with Benefits Eligible Date.

SECTION 2: GROUP APPLICATION/CHANGE INFORMATION (to be completed by applicant)

Last Name | **First Name** | **M.I.** | **Birthdate** / / | **Sex** ☐ MALE ☐ FEMALE | **Social Security Number**

Street Address | **City** | **State** | **ZIP Code** | **County** | **Email Address (if applicable)**

Home Phone (area code + 7 digit) | **Work Phone (area code + 7 digit)** | **Marital Status (circle one)** Single Married Widowed Divorced | **Prior Last Name**

Primary Care Physician ______

Are you an established patient? (circle one) Y N

If your spouse is not listed as a depenedent (only needed if other coverage) on this application, you must provide your spouse's birthday:________

DEPENDENT INFORMATION If applicable, if any dependent child is over the age of 26 and : an unmarried full-time student (Iowa only), aged 26-30 and honorably discharged from the military (Illinois only) or disabled (all states), you must attach documentation of a student's full-time status (Iowa only, e.g. class schedule, letter from college admissions office, etc).

Name (last, first, MI)	Relationship	Sex	DOB	Social Security #	Resides with employee?	County	Name of Primary Care Physician	Established patient? Y/N

OTHER COVERAGE

Medicare Coverage: If you or any dependent listed above will be covered by Medicare while enrolled in this health plan, please complete the following:

Enrollee Name	Medicare #	Part A Effective Date	Part B Effective Date	Part D Effective Date	Is Medicare eligibility due to:
					☐ Kidney Failure ☐ Disability
					☐ Kidney Failure ☐ Disability

Are you or any dependent listed on this application currently covered by other group health insurance or plan? ☐ Yes ☐ No If Yes, please complete the following and indicate if double coverage is desired: ☐ Yes ☐ No

NAME OF INSURED	EMPLOYER/GROUP	GROUP #/ POLICY #	INSURANCE CO./CARRIER	SUBSCRIBER #	POLICY COVERAGE DATES	FAMILY MEMBERS COVERED

Do you receive any Veteran Affairs benefits? ☐ Yes ☐ No If yes, which VA facility______

If you are the legal guardian or stepparent, are you required by decree or court order to provide health coverage for that dependent? ☐ Yes ☐ No
If yes, attach a copy of that court decree.

SECTION 3: MEDICAL HISTORY (fraud or material misrepresentation of facts may be cause for rescission of coverage)

Employee Height (Ft/In)	Employee Weight (Lbs)	Spouse Height (Ft/In)	Spouse Weight (Lbs)
Dependent A Height (Ft/In)	Dependent A Weight (Lbs)	Dependent B Height (Ft/In)	Dependent B Weight (Lbs)

Have you or any dependent ever received treatment (including medication) or been diagnosed by a physician or mental health professional with:

- Heart Disease ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- Circulatory Disorder ☐ Yes ☐ No
- Chest Pain ☐ Yes ☐ No
- Blood Pressure Disorder ☐ Yes ☐ No
- Elevated Cholesterol ☐ Yes ☐ No
- Anemia or Blood Disorder ☐ Yes ☐ No
- Ulcers ☐ Yes ☐ No
- Stomach Disorder ☐ Yes ☐ No
- Liver/Pancreas Disorder ☐ Yes ☐ No
- Gallbladder Disorder ☐ Yes ☐ No
- Intestinal Disorder (Crohn's/Colitis) ☐ Yes ☐ No
- Hernia ☐ Yes ☐ No
- Rectal Disorder ☐ Yes ☐ No
- Menstrual Disorder ☐ Yes ☐ No
- Genital Disorder ☐ Yes ☐ No
- Sexual Dysfunction ☐ Yes ☐ No
- Pregnancy Complications ☐ Yes ☐ No
- Infertility ☐ Yes ☐ No
- Urinary Tract/Kidney/Bladder Disorder ☐ Yes ☐ No
- Prostate Disorder ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Thyroid Disorder ☐ Yes ☐ No
- Adrenal Disorder ☐ Yes ☐ No
- Lymph-nodes Enlargement ☐ Yes ☐ No
- Connective Tissue Disorder ☐ Yes ☐ No
- Allergy(ies) ☐ Yes ☐ No
- Asthma ☐ Yes ☐ No
- Emphysema ☐ Yes ☐ No
- Sinus or Nasal Disorder ☐ Yes ☐ No
- Lung Disease ☐ Yes ☐ No
- Shortness of Breath ☐ Yes ☐ No
- Arthritis ☐ Yes ☐ No
- Fibromyalgia ☐ Yes ☐ No
- Back Disorder ☐ Yes ☐ No
- Neck Disorder ☐ Yes ☐ No
- Joint Disorder ☐ Yes ☐ No
- Musculoskeletal Disorder ☐ Yes ☐ No
- Skin Disorder ☐ Yes ☐ No
- Chronic Fatigue Syndrome ☐ Yes ☐ No
- Epilepsy or Other Seizures ☐ Yes ☐ No
- Headaches or Migraines ☐ Yes ☐ No
- Multiple Sclerosis ☐ Yes ☐ No
- Cancer ☐ Yes ☐ No
- Tumor ☐ Yes ☐ No
- Abnormal Growth ☐ Yes ☐ No
- Carcinoma in Situ ☐ Yes ☐ No
- Eye Disorder ☐ Yes ☐ No
- Ear Disorder ☐ Yes ☐ No
- Attention Deficit Disorder ☐ Yes ☐ No
- Psychological Disorder ☐ Yes ☐ No
- Suicide Attempt ☐ Yes ☐ No
- Eating Disorder ☐ Yes ☐ No
- Organ or other type transplant or implant ☐ Yes ☐ No
- Breast Disorder ☐ Yes ☐ No
- Lupus ☐ Yes ☐ No
- AIDS, HIV or other Autoimmune Disease ☐ Yes ☐ No
- Any hospitalizations in the last 5 years ☐ Yes ☐ No
- Any future surgeries planned ☐ Yes ☐ No
- Any drug or alcohol problems ☐ Yes ☐ No
- Any related treatment/rehab for drug or alcohol problems ☐ Yes ☐ No
- In the last year, has anyone received medical treatment apart from routine physicals or innoculations? ☐ Yes ☐ No
- Do you or any of your dependents take any medicine, drugs, pills or require shots? ☐ Yes ☐ No
- In the past 12 months, have you or any of your dependents used tobacco products? ☐ Yes ☐ No
- Are you, your spouse or any dependent currently pregnant? ☐ Yes ☐ No

If any of the above questions are answered "Yes," please indicate the following information (attach additional page if needed):

Patient Name	Illness or Diagnosis	Dates of Treatment	Type of Treatment	Physician's Name	Current Status/ Medication and Dosage

SECTION 4: WAIVE GROUP COVERAGE

Waiver of Coverage

I decline coverage for:

- ☐ Myself and all dependents
- ☐ Spouse
- ☐ Dependent children

Declining coverage due to existence of other coverage:

- ☐ Spouse's Employer's Plan
- ☐ Covered by Medicare
- ☐ COBRA from prior employer
- ☐ Other ________________
- ☐ Individual Plan
- ☐ Medicaid
- ☐ VA Eligibility
- ☐ Tri-Care
- ☐ I (we) have no other coverage at this time

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable.

Employee Signature Date

SECTION 5: AGREEMENT FOR COVERAGE AND SIGNATURE

I understand, agree, and represent that: I have read this document or it has been read to me.The answers provided within this entire application for coverage are, to the best of my knowledge and belief, true and complete. Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the insurance carrier's other rights and requirements.

I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud. If this application for coverage is accepted, coverage will be effective on the date specified by the insurance carrier on the certificate of coverage/certificate of insurance.

I hereby enroll for benefits as indicated in Section 2 of this application, for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice. I understand that the information I have provided in this application will be used by the insurance carrier and its affiliates to make decisions regarding eligibility, enrollment, underwriting, and premium risk rating.

I understand that protected health information described in this form may be used by, or disclosed by, organizations and persons who are not subject to federal and state privacy laws. I understand that the medical information provided also includes my spouse and/or dependents' information. I understand that I may be asked for authorization to disclose my medical, claim, or benefit records at a later time. I understand I may revoke this authorization at any time by giving advance written notice to Health Alliance. Revocation of this authorization form will not affect actions Health Alliance and others took in reliance on this form prior to written notice of revocation. I understand that I should retain a duplicate copy of this application for my own records. A photographic copy of this acknowledgment shall be as valid as the original.

This application will become part of the contract between Health Alliance and me.

I authorize the insurance carrier to electronically transmit the information contained herein. If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

Employee Signature________________________________ **Date**________________