301 S. Vine St.
Urbana, Illinois 61801
1-800-851-3379
Fax: (217) 337-8055

# SMALL 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)

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

- ❑ INITIAL ENROLLMENT
- ❑ NEW GROUP
- ❑ NEW HIRE
- ❑ OPEN ENROLLMENT
- ❑ LATE ENROLLMENT
- ❑ SPECIAL ENROLLMENT
- ❑ CONTRACT CHANGE (see below)
- ❑ TRANSFER (from another location)

**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

**CONTRACT CHANGE:**

- ❑ ELECT CONTINUATION (COBRA) (20+ EMPLOYEES)
  - ❑ 18 mo. ❑ 29 mo. ❑ 36 mo.
- ❑ SPOUSAL CONTINUATION COVERAGE
- ❑ DEPENDENT CONTINUATION COVERAGE
- ❑ IMRF _____/_____/______
- ❑ RE-ENROLL FROM LAY-OFF
- ❑ RE-ENROLL FROM LEAVE OF ABSENCE
- ❑ MOVED OUT OF SERVICE AREA
- ❑ LEFT EMPLOYMENT
- ❑ NON-BENEFIT ELIGIBLE TO BENEFIT ELIGIBLE
- ❑ ELECT 12 MONTHS STATE CONTINUATION
- ❑ DECEASED
- ❑ SWITCHED HEALTH PLANS
- ❑ CANCEL CONTRACT
- ❑ 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 | Social Security Number |
|---|---|---|---|---|---|
| | | | / / | ❑ Male ❑ Female | |

| 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) | Prior Last Name |
|---|---|---|---|
| | | Single Married Widowed Divorced | |

| Primary Care Physician | Are you an established patient? (circle one) |
|---|---|
| | Y N |

| Name of Group/Employer | Occupation | Hire Date (❑ Active ❑ Retired) | Hours Worked Per Week |
|---|---|---|---|
| | | / / | |

## SECTION 3: DEPENDENT INFORMATION (List all dependents covered. If adding or deleting a dependent, list only that dependent. Write name as it should appear on ID card.)

| Last Name / First Name / M.I. | Social Security # | Relationship | Resides with Employee | Sex | Birthdate | Address (if different from Employee address) |
|---|---|---|---|---|---|---|
| Name of Primary Care Physician | | | ❑ Yes ❑ No County: | M F | | |
| Name of Primary Care Physician | | | ❑ Yes ❑ No County: | M F | | |
| Name of Primary Care Physician | | | ❑ Yes ❑ No County: | M F | | |
| Name of Primary Care Physician | | | ❑ Yes ❑ No County: | M F | | |

**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 the court decree.**

## SECTION 4: WAIVE GROUP COVERAGE

❑ **I decline or refuse the medical coverage indicated below.**
I acknowledge that the available coverage has been explained to me by my employer. I have been given the opportunity to apply for the available coverage and am electing not to apply for myself (and/or my dependents). I understand that a medical examination at my own expense may be required if I desire to apply for such health and accident benefit coverage at some later date for myself (and/or my dependents).

| **Check all applicable statements:** | **Reason for declining coverage (check one):** |
|---|---|
| ❑ I waive health plan coverage for myself | ❑ Covered by spouse's coverage |
| ❑ I waive health plan coverage for my spouse | ❑ Covered by CHAMPUS or CHAMPVA |
| ❑ I waive health plan coverage for my children | ❑ Other (explain) ____________________ |

**Print Name** ____________________ **Signature** ____________________ **Date** __________

**Name of Carrier** ____________________ **Policy Number** ____________________

## SECTION 5: OTHER HEALTH INSURANCE INFORMATION

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

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 | 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 |
|---|---|---|---|---|---|---|
| | | | | | __________ to __________ | |
| | | | | | __________ to __________ | |

Do you receive any Veteran Affairs (VA) benefits? ❑ Yes ❑ No If yes, which VA facility? ____________________

## SECTION 6: AGREEMENT FOR COVERAGE AND SIGNATURE (this form must be signed)

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 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 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 may be asked for authorization to disclose my medical, claim or benefit records at a later time. 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.

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.

This application will become part of the contract between Health Alliance and me. By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

**Applicant Signature** ____________________ **Date** __________

**Dependent Signature** ____________________ **Date** __________
***(age 18 and over)***

**Dependent Signature** ____________________ **Date** __________
***(age 18 and over)***

**Dependent Signature** ____________________ **Date** __________
***(age 18 and over)***