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IL SMALL GROUP APPLICATION CHANGE FORM

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

PLAN DESCRIPTION		GROUP #	
EFFECTIVE DATE		SUB GROUP #	
REASON FOR SUBMITTING APPLICATION: Mark all that apply. (Attach Certificate of Creditable Coverage if applicable)			
<input type="checkbox"/> NEW HIRE <input type="checkbox"/> NEW GROUP <input type="checkbox"/> ADD DEPENDENT		<input type="checkbox"/> DEMOGRAPHIC CHANGE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> DELETE DEPENDENT	
		<input type="checkbox"/> CONTRACT CHANGE (see below) <input type="checkbox"/> SPECIAL ENROLLMENT	
		<input type="checkbox"/> TERMINATION (see below) <input type="checkbox"/> TRANSFER (from another location)	
POLICY/DEPENDENT CHANGE (CHECK ALL THAT APPLY): <input type="checkbox"/> MARITAL STATUS CHANGE: <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LEGAL SEPARATION <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> LOSS OF COVERAGE: DATE OF LOSS ____/____/____		CONTRACT CHANGE: <input type="checkbox"/> ELECT CONTINUATION (COBRA)* (20+ EMPLOYEES) <input type="checkbox"/> 18 mo. <input type="checkbox"/> 29 mo. <input type="checkbox"/> 36 mo. <input type="checkbox"/> SPOUSAL CONTINUATION COVERAGE* <input type="checkbox"/> DEPENDENT CONTINUATION COVERAGE* *More information on COBRA and Continuation coverage can be found in the member policy.	
		TERMINATION REASON: <input type="checkbox"/> DECEASED ____/____/____ <input type="checkbox"/> SWITCHED HEALTH PLANS ____/____/____ <input type="checkbox"/> CANCEL CONTRACT <input type="checkbox"/> LEFT EMPLOYMENT ____/____/____ <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number (required for IRS 1095B)	
Street Address		City	State	ZIP Code	County	Email Address*
Primary Phone (area code + 7 digit)	Secondary Phone (area code + 7 digit)	Marital Status (circle one) Single Married Widowed Divorced		Prior Last Name		
Primary Care Physician (required for HMO or POS)				Are you an established patient? (circle one) Y N		
Name of Group/Employer	Occupation	Hire Date (<input type="checkbox"/> Active <input type="checkbox"/> Retired) ____/____/____		Hours Worked Per Week		

* Consent to receive an informational email about your Health Alliance membership. Yes No

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
Name of Primary Care Physician (required for HMO or POS)					<input type="checkbox"/> Yes <input type="checkbox"/> No County:	M	
Name of Primary Care Physician (required for HMO or POS)					<input type="checkbox"/> Yes <input type="checkbox"/> No County:	F	
Name of Primary Care Physician (required for HMO or POS)					<input type="checkbox"/> Yes <input type="checkbox"/> No County:	M	
Name of Primary Care Physician (required for HMO or POS)					<input type="checkbox"/> Yes <input type="checkbox"/> No County:	F	
Name of Primary Care Physician (required for HMO or POS)					<input type="checkbox"/> Yes <input type="checkbox"/> No County:	M	
Name of Primary Care Physician (required for HMO or POS)					<input type="checkbox"/> Yes <input type="checkbox"/> No County:	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):
<input type="checkbox"/> I waive health plan coverage for myself	<input type="checkbox"/> Covered by spouse's coverage
<input type="checkbox"/> I waive health plan coverage for my spouse	<input type="checkbox"/> Covered by CHAMPUS or CHAMPVA
<input type="checkbox"/> I waive health plan coverage for my children	<input type="checkbox"/> Other (explain) _____

Print Name _____ Signature _____ Date _____

Name of Carrier _____ Policy Number _____

SECTION 5: OTHER HEALTH INSURANCE INFORMATION

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? _____

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:
				<input type="checkbox"/> Kidney Failure <input type="checkbox"/> Disability
				<input type="checkbox"/> Kidney Failure <input type="checkbox"/> Disability

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 _____ Dependent Signature _____ Date _____
(age 18 and over)