Health Alliance Individual
Plan Change Form

Health Alliance INDIVIDUAL PLANS℠

If you have any questions, please contact your agent, or call 1-877-660-1962, Monday through Friday, 8 a.m.–5 p.m.

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 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 Election Period (SEP) attestation form with your application. You may be required to provide documentation to support the qualifying event.

Section A: Member Information

Policyholder Name ____________________

Member Number: | 9 | 4 | | | | | | | | – | | |

Required: Primary Care Physician (PCP) ____________________
Are you an established patient? ❑ Yes ❑ No

Dependent Name ____________________

Member Number: | 9 | 4 | | | | | | | | – | | |

Required: Primary Care Physician (PCP) ____________________
Are you an established patient? ❑ Yes ❑ No

Dependent Name ____________________

Member Number: | 9 | 4 | | | | | | | | – | | |

Required: Primary Care Physician (PCP) ____________________
Are you an established patient? ❑ Yes ❑ No

Dependent Name ____________________

Member Number: | 9 | 4 | | | | | | | | – | | |

Required: Primary Care Physician (PCP) ____________________
Are you an established patient? ❑ Yes ❑ No

Dependent Name ____________________

Member Number: | 9 | 4 | | | | | | | | – | | |

Required: Primary Care Physician (PCP) ____________________
Are you an established patient? ❑ Yes ❑ No

Dependent Name ____________________

Member Number: | 9 | 4 | | | | | | | | – | | |

Required: Primary Care Physician (PCP) ____________________
Are you an established patient? ❑ Yes ❑ No

Note: *Your member number is on the front of your Health Alliance ID card. Member numbers start with 94.*

Required Information
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: ❑ Policyholder ❑ Spouse/Civil Union Spouse ❑ Dependent Children

Section B: Plan Selection

Please choose one plan.

HMO Plan Name	
HMO 3150 Elite Silver	❑
HMO 3150 Methodist Silver	❑
HMO 3150 OSF Silver	❑
HMO 3500a Elite Silver	❑
HMO 3500a Methodist Silver	❑
HMO 3500a OSF Silver	❑
HMO 3800 Elite Bronze	❑
HMO 3800 Methodist Bronze	❑
HMO 3800 OSF Bronze	❑
HMO 4000b Elite Silver	❑
HMO 4000b Methodist Silver	❑
HMO 4000b OSF Silver	❑
HMO 5000c Elite Silver	❑
HMO 5000c Methodist Silver	❑
HMO 5000c OSF Silver	❑

POS Plan Name	
POS 5000a Elite Bronze	❑
POS 5000a Methodist Bronze	❑
POS 5000a OSF Bronze	❑
POS 6000a Elite Bronze	❑
POS 6000a Methodist Bronze	❑
POS 6000a OSF Bronze	❑
POS 7250 Elite Silver	❑
POS 7250 Methodist Silver	❑
POS 7250 OSF Silver	❑
POS HSA 6650 Elite Bronze	❑
POS HSA 6650 Methodist Bronze	❑
POS HSA 6650 OSF Bronze	❑

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: _____