Washington Enrollment Request Form for Individual & Family Health Insurance Coverage

Health Alliance INDIVIDUAL PLANS℠

For assistance in completing this form, visit HealthAlliance.org or call 1-877-750-3515. Mail your completed form to Health Alliance Northwest Health Plan, ATTN: Individual Enrollment, 301 S. Vine St., Urbana, IL 61801. You may also email your completed form to individualenrollment@healthalliance.org or fax it to 217-337-8055.

INSTRUCTIONS:

1. Any information you provide in this form is confidential.
2. The answers you provide in this form must be true and complete to the best of your knowledge and belief. Do not leave any question unmarked.
3. An intentional misrepresentation may result in your policy being modified or terminated or in claims being reduced or denied.
4. You should have the following information available for each person requesting coverage:
   - Social Security Number and date of birth (If you, or your dependent(s), currently do not have a Social Security Number assigned, please note that in the section below)
   - Information about any current insurance coverage
   - Personal health information
5. For purposes of this form, the term "dependent" refers to any child up to age 26 for whom you are requesting coverage, regardless of whether the child may be considered a dependent for tax or other purposes.

Primary Applicant Information			
Name (Last)	(First)		(MI)
Residential Street Address:			Apt. #:
City:	State:	ZIP:	County:
Mailing Address (if different):			Apt. #:
City:	State:	ZIP:	County:
Primary Phone Number: ( )	Secondary Phone Number: ( )		
Email Address:			
Date of Birth: / /	Social Security Number:	Gender: ❑ Male ❑ Female	
Please check one of the following boxes: ❑ New Enrollee ❑ Dependent Addition ❑ Plan Change ❑ SEP (Outside the open enrollment period, you must have a Qualifying Event to apply for coverage and must include the Special Election Period attestation form.)			
Requested Effective Date: _____ (Coverage not in force until Health Alliance receives your form and determines the effective date.)			
Required In the last six 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/Civil Union Spouse ❑ Dependent Children			
Required Primary Care Physician (PCP): Name (last) (first)		Are you an established patient? ❑ Yes ❑ No	

Would you like to receive your member materials electronically? ❑ Yes ❑ No If yes, please authorize below.

I authorize Health Alliance to provide the plan documents and materials to me through HealthAlliance.org. I acknowledge that I have access to resources that allow me to access my Health Alliance account and have a current email address on file with Health Alliance. I understand I will be notified when documents become available or updated on my Health Alliance account. I understand I may request a paper copy at any time and/or revoke electronic distribution of materials at any time by contacting Health Alliance.

Electronic Distribution Authorization Signature _____

Date: _____

Dependent Information

List all family members you wish to include under the policy. For more information regarding the available coverage, please check with Health Alliance.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Spouse/Civil Union Spouse Name (Last) (First) (MI)	
Social Security Number (for internal use only):	Date of Birth (mm/dd/yyyy):
Gender: ☐ Male ☐ Female	
Primary Care Physician (PCP):	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth (mm/dd/yyyy):
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Primary Care Physician (PCP):	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth (mm/dd/yyyy):
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Primary Care Physician (PCP):	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth (mm/dd/yyyy):
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Primary Care Physician (PCP):	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth (mm/dd/yyyy):
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Primary Care Physician (PCP):	

Plan Options: Please choose one.

☐ POS 1500 Gold	☐ Summit 3500c Silver
☐ Summit HSA 6500 Bronze	☐ Summit 5500 Bronze

Additional Coverage

Vision:

☐ VSP Vision Choice Plan $20 exam and materials copay

Current/Prior Coverage Information

For EACH person listed on this form, please indicate any current public health insurance coverage (for example, Medicare, HFS Medical Card or other federal and state programs, like the VA) or private health insurance. Each person applying for insurance must be listed below. If you currently do not have coverage, please indicate **NONE**.

Self Name (Last) (First) (MI)

Current Coverage: ☐ None ☐ Medicare ☐ Other Public ☐ Employer Group ☐ Private (Insurer ____________________________)

☐ Individually Purchased ☐ VA (Facility ____________________________) ☐ Other (____)

Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________

Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Spouse/Civil Union Spouse Name (Last) (First) (MI)

Current Coverage: ☐ None ☐ Medicare ☐ Other Public ☐ Employer Group ☐ Private (Insurer ____________________________)

☐ Individually Purchased ☐ VA (Facility ____________________________) ☐ Other (____)

Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________

Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Dependent Name (Last) (First) (MI)

Current Coverage: ☐ None ☐ Medicare ☐ Other Public ☐ Employer Group ☐ Private (Insurer ____________________________)

☐ Individually Purchased ☐ VA (Facility ____________________________) ☐ Other (____)

Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________

Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Dependent Name (Last) (First) (MI)

Current Coverage: ☐ None ☐ Medicare ☐ Other Public ☐ Employer Group ☐ Private (Insurer ____________________________)

☐ Individually Purchased ☐ VA (Facility ____________________________) ☐ Other (____)

Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________

Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Dependent Name (Last) (First) (MI)

Current Coverage: ☐ None ☐ Medicare ☐ Other Public ☐ Employer Group ☐ Private (Insurer ____________________________)

☐ Individually Purchased ☐ VA (Facility ____________________________) ☐ Other (____)

Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________

Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Dependent Name (Last) (First) (MI)

Current Coverage: ☐ None ☐ Medicare ☐ Other Public ☐ Employer Group ☐ Private (Insurer ____________________________)

☐ Individually Purchased ☐ VA (Facility ____________________________) ☐ Other (____)

Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________

Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

* If answering "Yes" please carefully read the following notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT & HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Health Alliance. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the form. After the form has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.
3. It is recommended that you do not terminate your present contract until you are certain that your form for the new contract has been received by Health Alliance.

Acknowledgement & Signature

Signature – Adult applicants must sign this form below. Parent or guardian signature is required for applicants under the age of 18. By signing this form, you certify the following:

- I have read this document or it has been read to me.
- The answers provided within this entire form for coverage are, to the best of my knowledge, true and complete.
- Neither Health Alliance nor the producer 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 form, this policy may be canceled retroactively, in which case any claim I submit may not be paid by Health Alliance. I understand that if I intentionally omit or provide false information on or in relation to this form that I may face legal liability, including legal action based on fraud.
- It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I understand that the information I have provided in this form will be used by Health Alliance and its affiliates to make decisions regarding eligibility, enrollment and premium risk rating.

I understand that the medical information provided also includes my spouse/civil union 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 that I should retain a duplicate copy of this form for my own records.

I understand that no coverage shall be in force until received by Health Alliance. If received, coverage will be in force as of the effective date determined by Health Alliance.

I understand that this form will become part of the contract between Health Alliance and me.

I understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws.

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 took in reliance on this form prior to the written notice of revocation.

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.

I agree this Authorization shall be valid for two and one-half (2 ½) years from the latest signature date below.

If this form was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this form but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the form, 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 am signing of my own free will.

I HAVE READ AND CONSIDERED THE CONTENTS OF THIS FORM. BY SIGNING THIS FORM, I HEREBY AUTHORIZE THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ Date _____
Primary Applicant (or Authorized Legal Representative) Signature

_____ Date _____
Spouse/Civil Union Spouse Signature (ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

TO BE COMPLETED BY PRODUCER
Producer Information

I certify that:

- All answers provided in this form were completed by or provided by the enrollee.
- I have reviewed this enrollment form to ensure that all required items have been completed.
- I am not aware of any information not disclosed on this enrollment form relating to the health, habits or reputation of any person listed on this enrollment form, which might have a bearing on the risk.

Producer

Producer Name:	ID#/Code:
Agency:	Phone: ( )
Email:	

Producer Signature: _____

Date Signed: _____
(A faxed signature shall be valid as an original signature.)