Additional Plans
Selection Form

Health Alliance Individual and Family Plans give you and your family great healthcare coverage.

We list our five most popular plans on the plan change form. However, we have additional options for you to choose from. If you'd like one of these additional plans, please check the box next to the plan below and include with your application.

- ☐ HMO 2500 Elite Gold
- ☐ HMO 5000 Elite Bronze*
- ☐ HMO 5000 Riverside Bronze*
- ☐ POSC 1000 Elite Gold
- ☐ POS 5000 Elite Bronze
- ☐ POS 6000 Elite Bronze
- ☐ POS HSA 6750 Elite Bronze

Plans already on the form: HMO 2500 Elite Silver, HMO 3500 Elite Silver, HMO 5000 Elite Silver, POS 6000 Elite Silver, POS 7250 Elite Silver

Please submit your completed plan change form and this form (if you selected one of the additional plans).

Email: individualenrollment@healthalliance.org

Fax: 217-902-9755

Mail:

Health Alliance
ATTN: Enrollment
3310 Fields South Drive
Champaign, IL 61822

*These plans are only available in select areas. Please see the plan book for your area for complete information.

Health Alliance Individual
Plan Change Form

Health Alliance INDIVIDUAL PLANS℠

This form is NOT for Marketplace plan members. If you are a Marketplace plan member, please go to healthcare.gov to make changes to your plan.

If you have any questions, please contact your agent, or call 1-866-247-3296, Monday through Friday, 8 a.m.–5 p.m. CST

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 Enrollment Period (SEP) attestation form with your application. SEP attestation forms can be found on HealthAlliance.org. If applying during a Special Enrollment Period (outside the normal Open Enrollment Period), you will be required to provide supporting documentation to verify your qualifying event. If you are adding dependents, please submit the "Illinois Application for Individual and Family Health Insurance Coverage. You can find that at HealthAlliance.org."

Section A: Member Information

_____
Policyholder Name (Required)

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Member Number (Required)

_____
Dependent Name

_____
Dependent Name

_____
Dependent Name

_____
Dependent Name

Required 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: ☐Primary Applicant ☐Spouse/Civil Union Spouse
☐Dependent Children _____

Section B: Plan Selection

Please choose one plan.

HMO Plan Name	
HMO 2500 Elite Silver	☐
HMO 3500 Elite Silver	☐
HMO 5000 Elite Silver	☐

POS Plan Name	
POS 6000 Elite Silver	☐
POS 7250 Elite Silver	☐

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: _____