



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

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)

GROUP INFORMATION: Group Number: _____ Group Name: _____		PLAN TYPE: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Other _____	
REASON FOR SUBMITTING APPLICATION: Mark only one. (Attach Certificate of Creditable Coverage if applicable) <input type="checkbox"/> NON-BENEFIT ELIGIBLE TO BENEFIT ELIGIBLE (part-time to full-time) <input type="checkbox"/> NEW HIRE <input type="checkbox"/> ACTIVE <input type="checkbox"/> LATE ENROLLMENT <input type="checkbox"/> NEW GROUP <input type="checkbox"/> RETIRED <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> SPECIAL ENROLLMENT (Marriage, Divorce, Birth, Death or Adoption)			
POLICYHOLDER/DEPENDENT CHANGE (CHECK ALL THAT APPLY): <input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> NAME CHANGE: FORMER NAME _____ <input type="checkbox"/> DELETE DEPENDENT <input type="checkbox"/> MARITAL STATUS CHANGE: <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> ADDRESS CHANGE _____ <input type="checkbox"/> WIDOWED <input type="checkbox"/> LEGAL SEPARATION <input type="checkbox"/> PHONE CHANGE _____ <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> LOSS OF COVERAGE: DATE OF LOSS ____/____/____		REASON FOR CHANGE: CONTINUATION ELECTED <input type="checkbox"/> COBRA <input type="checkbox"/> RE-ENROLL FROM LAY-OFF <input type="checkbox"/> STATE CONTINUATION <input type="checkbox"/> RE-ENROLL FROM LEAVE OF ABSENCE <input type="checkbox"/> SPOUSAL COVERAGE (IL ONLY) <input type="checkbox"/> MOVED OUT OF SERVICE AREA <input type="checkbox"/> DEPENDENT COVERAGE (IL ONLY) <input type="checkbox"/> LEFT EMPLOYMENT <input type="checkbox"/> IMRF ____/____/____ Date of Termination: ____/____/____ <input type="checkbox"/> DECEASED <input type="checkbox"/> SWITCHED HEALTH PLANS <input type="checkbox"/> CANCEL COVERAGE <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	Social Security Number
			/ /	<input type="checkbox"/> MALE <input type="checkbox"/> 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

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

DEPENDENT INFORMATION If applicable, if any dependent child is over the age of 26 and : an unmarried full-time student (Iowa only), aged 26-30 and honorably discharged from the military (Illinois only) or disabled (all states), you must attach documentation of a student's full-time status (Iowa only, e.g. class schedule, letter from college admissions office, etc).

Name (last, first, MI)	Relationship	Sex	DOB	Social Security #	Resides with employee?	County	Name of Primary Care Physician	Established patient? Y/N

OTHER COVERAGE

Medicare Coverage: 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	Part D 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

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

Do you receive any Veteran Affairs benefits? Yes No If yes, which VA facility _____

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 that court decree.

SECTION 3: MEDICAL HISTORY (fraud or material misrepresentation of facts may be cause for rescission of coverage)

Employee Height (Ft/In)	Employee Weight (Lbs)	Spouse Height (Ft/In)	Spouse Weight (Lbs)
Dependent A Height (Ft/In)	Dependent A Weight (Lbs)	Dependent B Height (Ft/In)	Dependent B Weight (Lbs)

Have you or any dependent ever received treatment (including medication) or been diagnosed by a physician or mental health professional with:

Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergy(ies)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ or other type transplant or implant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus or Nasal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS, HIV or other Autoimmune Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Pressure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	In the last year, has anyone received medical treatment apart from routine physicals or inoculations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Elevated Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or any of your dependents take any medicine, drugs, pills or require shots?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia or Blood Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	In the past 12 months, have you or any of your dependents used tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you, your spouse or any dependent currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Liver/Pancreas Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Gallbladder Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Intestinal Disorder (Crohn's/Colitis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Musculoskeletal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Rectal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Fatigue Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Menstrual Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Other Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Genital Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches or Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sexual Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pregnancy Complications	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Infertility	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Urinary Tract/Kidney/Bladder Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Growth	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Prostate Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Carcinoma in Situ	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Thyroid Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Adrenal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Attention Deficit Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Lymph-nodes Enlargement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychological Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Connective Tissue Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		

If any of the above questions are answered "Yes," please indicate the following information (attach additional page if needed):

Patient Name	Illness or Diagnosis	Dates of Treatment	Type of Treatment	Physician's Name	Current Status/ Medication and Dosage

SECTION 4: WAIVE GROUP COVERAGE

Waiver of Coverage I decline coverage for: <input type="checkbox"/> Myself and all dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent children	Declining coverage due to existence of other coverage: <input type="checkbox"/> Spouse's Employer's Plan <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> COBRA from prior employer <input type="checkbox"/> Other _____ <input type="checkbox"/> I (we) have no other coverage at this time	I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable.
	<input type="checkbox"/> Individual Plan <input type="checkbox"/> Medicaid <input type="checkbox"/> VA Eligibility <input type="checkbox"/> Tri-Care	Employee Signature _____ Date _____

SECTION 5: AGREEMENT FOR COVERAGE AND SIGNATURE

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

This application will become part of the contract between Health Alliance and me.

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.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

Employee Signature _____ Date _____