SimpleCare

2017 SMALL GROUP PLAN

ALLIANT HEALTH PLANS

EMPLOYEE ENROLLMENT APPLICATION AND CHANGE IN COVERAGE FORM

NAME OF YOUR EMPLOYER/GROUP: _____

To help us process your application promptly, please remember to:

1. Print all answers in **blue or black** ink only. Pencil will not be accepted. Fill in the boxes [□] like this --> ■.
2. Please have available the following information for all applicants: social security number, date of birth and address.
3. To correct any errors, cross out the incorrect information and write your initials next to the correct information.
4. Make sure you personally sign the application as the primary applicant. If your spouse or any dependent(s) age 18 and over is also applying, he/she must also personally sign the appropriate signature line.

Section A - Coverage Information

Application Type (select one):

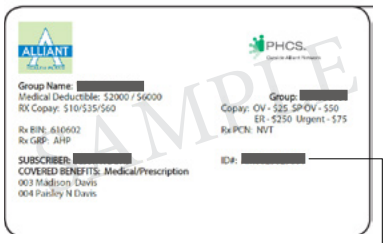
□ New Coverage: Employee Hire Date: _____

□ Change policy coverage:
Please provide your current Member ID: _____

□ Add dependent(s) to current coverage:
Please provide your current Member ID: _____

□ COBRA coverage:
Please provide your current group policy number: _____

Front of Sample ID Card



Your Member ID number

Requested Effective Date (MM/DD/YYYY): _____

Open Enrollment

Open Enrollment is the annual period of time during which you may apply for coverage, change plans or add dependents. The time frame for open enrollment is determined by employer and renewal date.

Applications must be received during the Open Enrollment period. If you are applying outside of the Open Enrollment period, you must qualify for Special Enrollment Period (SEP) due to a change in family status or loss of other health coverage within the last 60 days. You must provide acceptable documentation showing proof and date of your qualifying life event.

SPECIAL ENROLLMENT EVENTS

Please check the special enrollment period event you experienced (documentation will be required):

□ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium

□ Involuntary loss of employer sponsored health insurance

□ Loss of coverage for dependent child who has reached age 26

□ Exhaustion of COBRA

□ Marriage/Divorce

□ Adoption or placement for adoption or appointment of guardianship

□ Birth of a dependent-child

□ OTHER (please describe):
_____
_____

Please provide the date of the special event (MM/DD/YYYY): _____

NOTE: Special Events require supporting documents (e.g. Marriage Certificate/Divorce Decree, adoption certificate, loss of employer coverage letter, etc.). Please provide supporting documents as an attachment to this application. Special Events listed on this form are the most common qualifying life events and not a complete list. If you have questions regarding your special event, please call Customer Service at (800) 811-4793.

Interpreter and translation services are available in all languages. If you or a family member needs Spanish-language assistance to understand this document, you may request it at no additional cost by calling (800) 811-4793 and selecting option #3 at the prompt.

Servicios de interpretación y traducción están disponibles en todos los idiomas. Si usted o un miembro de la familia necesita ayuda en español para entender este documento, puede solicitarlo sin costo adicional llamando al (800) 811 hasta 4793 y seleccionando la opción # 3 en el indicador.

Section B - Primary Applicant Information

Last Name	First Name	MI	Gender ☐ M ☐ F	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow
Social Security Number (SSN)	No SSN? Check one ☐ Newborn ☐ Green Card ☐ Passport List Number:			Date of Birth (MM/DD/YYYY)
Physical Address				
City		State	Zip Code	County
Mailing Address				
City		State	Zip Code	County
Billing Address (if different than above)				
City		State	Zip Code	County
Primary Phone Number ( )	Secondary Phone Number ( )	Email		
Would you like to receive all policy documents via your email address above? ☐ Yes ☐ No				
What is your preferred written language? ☐ English ☐ Spanish		What is your preferred spoken language? ☐ English ☐ Spanish		

Section C - Spouse to be Covered Information

Last Name	First Name	MI	Gender ☐ M ☐ F
Social Security Number	Date of Birth (MM/DD/YYYY)	Within the past 6 months, have you used tobacco? (4 or more times per week on average) ☐ Yes ☐ No	

Section D - Child Dependents to be Covered Information *(All fields are required. Please attach a separate sheet if necessary.)*

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your child(ren), or your spouse's child(ren) (to the end of the calendar month in which they turn age 26). (List all dependents beginning with the eldest.)

Last Name	**First Name**	**MI**	**Sex** (circle)	**DOB (MM/DD/YYYY)**	**Social Security Number**	**Tobacco User** (circle)	**Relationship to Applicant**
			M F			Y N	☐ Biological Child ☐ Other: _____
			M F			Y N	☐ Biological Child ☐ Other: _____
			M F			Y N	☐ Biological Child ☐ Other: _____
			M F			Y N	☐ Biological Child ☐ Other: _____

Are all applicants listed on this application legal residents of the United States and residents of the state in which you are applying for coverage? ☐ Yes ☐ No

Are all applicants listed on this application United States citizens, nationals or lawfully present non-citizens? ☐ Yes ☐ No

Section E - Select Medical Coverage

Plan Name and Deductible/Coinsurance Options

Into which plan are you enrolling (ask your HR Dept. if unsure about your choices)

Please provide the PLAN Name and ID: (example: SimpleCare 50008)

Section F - Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, who? _____

Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits? ☐ Yes ☐ No

If YES, who and reason: _____

Do you or anyone applying for coverage currently have health care coverage? ☐ Yes ☐ No

If **YES**, please provide the following:

Name(s) of covered persons (If the whole family, write ALL in space below.)	Member ID(s) or Policy ID Number(s)
Name and phone number of prior carrier(s)	
Type of Coverage ☐ Group ☐ Individual	Effective Date of Coverage

Will you be canceling this coverage if approved for Alliant Health Plans coverage? ☐ Yes ☐ No

If YES, what is the cancellation date? _____

Section G: Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

Eligible Employee

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Alliant Health Plans as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employees do not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible Dependent (if offered by the employer):

- Employee's spouse, or child(ren) under age 26, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26 (through age 25). Coverage for children will end on the last day of the month in which the child reaches age 26.

The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)

- Dependents eligible for continuous coverage under state or federal laws.

- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Alliant Health Plans and myself or my authorized representative.
- I acknowledge and agree that the cell phone number and the contact information that I have provided to Alliant may be used to contact me to pursue any debt collection or to correspond with me regarding my account. I authorize Alliant or its contractors or agents to contact me regarding debt collection or my account by using my cell phone number or other forms of identification provided to Alliant. I hereby acknowledge that Alliant or its contractors or agents may contact me using an auto-dialer.

□ **By shading this box, I authorize and expressly consent that Alliant Health Plans and its affiliated companies may send email communications instead of sending communications by mail, including but not limited to legally required Plan Notices, enrollment, billing and explanation of benefits statements, to the email address I have provided on this Application. I understand that I can revoke this authorization or request paper copies at any time free of charge by contacting Alliant Health Plans customer service at (800) 811-4793.**

I give this authorization for and on behalf of any eligible dependents and myself if covered by Alliant Health Plans. I am acting as their agent and representative.

I hereby acknowledge that Alliant Health Plans has informed me of the following prior to my enrollment in their health care coverage plan:

- number, mix and location of participating/network health care providers;
- limitations of choices of participation/network health care providers;
- disclosure of contractual relationship between participation/network provider and Alliant Health Plans;
- application shall be altered solely by the applicant or with his or her written consent.

Authorization for Use of Protected Health Information

By signing below: I authorize Alliant Health Plans, or an agent/broker, subsidiary or affiliate that has a business associate contract with Alliant Health Plans, to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, MIB, Inc., formerly Medical Information Bureau (MIB), and/or insurance support organizations.

This authorization is subject to revocation at any time by written notice to Alliant Health Plans except to the extent that Alliant Health Plans has already taken action in reliance on this authorization. If I revoke this authorization after I initially apply for coverage, I understand that I/we will not be considered for coverage. If I revoke this authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that if my and/or my family's information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans governed by federal privacy regulations, my/our information might be re-disclosed by any of those recipients and will not be protected by federal privacy regulations. A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

Authorization for use of protected health information (PHI) is valid for the initial term of the policy, automatically renewing as the policy renews, unless written revocation is provided by the policy holder. Failure to renew the policy will result in revocation of authorization, effective 24 months from the date of termination.

Sign Here	Applicant signture	Date (MM/DD/YYYY)

ONLY USE THIS PAGE IF YOU ARE DECLINING COVERAGE

DECLINING COVERAGE: By checking this box, I herby certify that I have been given the opportunity to apply for the available group benefits offered by my employer, the benefits have been explained to me, and I and/or my dependents(s) decline to participate. Neither I nor my dependents(s) were induced or pressured by my employer or agent into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be restricted in doing so.

If you are declining coverage, please provide a reason for declining:

Section H: EMPLOYEE DECLINING Information			
Last Name	First Name	MI	EE ID or Last 4-digits of SSN

Sign Here	Applicant signture	Date (MM/DD/YYYY)

Special Enrollment Rights

If you declined enrollment for yourself or your dependent(s) (including a spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- Either your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

In these cases, you may be able to enroll yourself and your dependents provided that you request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Abbreviated Notice of Insurance Information Practices

PRIVACY ACT. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. We need your answers to decide if you qualify for coverage. We are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals.

ALL DATA CONFIDENTIAL. Official Code of Georgia, Code Section 33-39-5, subsection (c) (1 through 4) requires that:

1. Personal information may be collected from persons other than the individual or individuals proposed for coverage;
2. Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization;
3. A right of access and correction exists with respect to all personal information collected; and,
4. The notice prescribed in subsection (b) of the above referenced Code Section will be furnished to the applicant or policyholder upon request.

ACCESS TO YOUR DATA. You have the right to see or obtain a photocopy of your personal information which we have. You also have the right to send us a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of our information practices, please contact Alliant Health Plans Customer Service at (800) 811-4793.

Language Assistance

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Alliant Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (800) 811-4793.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Alliant Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (800) 811-4793.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Alliant Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는(800) 811-4793 로 전화하십시오.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱Alliant Health Plans]方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 (800) 811-4793。

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યા હો તેમ ા ંથી કોઇને [એસબીએમ ક ર્યક્રમન ા ં ન મ મ કો] વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ ા ં પ્ર મ કરી શક ર્ છે. દભ વષર્ો િ ત કરિ મ ટે,આ [અહીં દ ખલ કરો નાંબર] પર કોલ કરો(800) 811-4793.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Alliant Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (800) 811-4793.

እርስዎ፣ወይም እርስዎ የሚያግዙትግለሰብ፣ ስለAlliant Health Plansጥያቄ ካላቸሁ፣ ያለ ምንም ክፍያበቋ ንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸሁ። ከአስተርጓሚ ጋር ለመነጋገር፣(800) 811-4793 ይደውሉ።

यदिआपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Alliant Health Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधकिार है। ककसी भिाषषए से बात करने के लिए, (800) 811-4793 पर कॉकिरें।

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Alliant Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan (800) 811-4793.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Alliant Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 811-4793.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Alliant Health Plans ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب (800) 811-4793.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Alliant Health Plans, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para (800) 811-4793.

اگر شما، اي کسی که شما به او کمک مي‌کنيد ، دروم رد سوال Alliant Health Plans، داشته باشيد حق اين را داريد که کمک به زبان خود را به طور رايگان دريافت نماييد (800) 811-4793. تماس حاصل نماييد

Falls Sie oder jemand, dem Sie helfen, Fragen zum Alliant Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 811-4793 an.

ご本人様、またはお客様の身の回りの方でも Alliant Health Plans についてご質問がござ いましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(800) 811-4793までお電話ください。

Non-Discrimination

Alliant Health Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

TTY/TDD

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-(800) 811-4793 (TTY/TDD: 1-(800) 811-4793).