LARGE GROUP PLAN

EMPLOYEE ENROLLMENT AND CHANGE IN COVERAGE FORM

Use this form to Enroll, Change or Waive Coverage (Print in black or blue ink)

EMPLOYER NAME ______________________________ **GROUP ID**______________________ **SUB**________ **PLAN** ______________

Section A - Coverage Information

Employee Name______________________________ Date of Hire ____________________ Effective Date ____________________

Employment Status ☐ Active ☐ Leave of Absence ☐ Retired ☐ Disabled ☐ COBRA Date________Reason________________

Enrollment Type ☐ New Enrollment ☐ Add Dependent(s) ☐ Drop Dependent(s) ☐ Open Enrollment ☐ Waiving Coverage

Qualifying Life Event ***DOCUMENTATION REQUIRED**

☐ Marriage* ☐ Divorce* ☐ Birth / Adoption* ☐ Loss of Coverage*

☐ Other ________________________________ Event Date (MM/DD/YYYY) ____

Section B - Employee Information

Last Name	First Name		MI
Date of Birth	Social Security Number		
Gender ☐ M ☐ F	Disabled? ☐ Y ☐ N		
Physical Address			
City	State	Zip Code	County
Mailing Address			
City	State	Zip Code	County
Phone Number / Cell Number	Email		
Would you like to receive policy documents via your email address above? ☐ Yes ☐ No			

Section C - Dependent Information

Spouse Information

Last Name	First Name		MI
Social Security Number	Date of Birth (MM/DD/YYYY)	Gender ☐ M ☐ F	Disabled? ☐ Y ☐ N

Child Information

Last Name	First Name	MI	Is this a "Step-Child"? ☐ Y ☐ N
Social Security Number	Date of Birth (MM/DD/YYYY)	Gender ☐ M ☐ F	Disabled? ☐ Y ☐ N

Child Information

Last Name	First Name	MI	Is this a "Step-Child"? ☐ Y ☐ N
Social Security Number	Date of Birth (MM/DD/YYYY)	Gender ☐ M ☐ F	Disabled? ☐ Y ☐ N

Child Information

Last Name	First Name	MI	Is this a "Step-Child"? ☐ Y ☐ N
Social Security Number	Date of Birth (MM/DD/YYYY)	Gender ☐ M ☐ F	Disabled? ☐ Y ☐ N

Section D - Waiving/Other Coverage

COMPLETE IF WAIVING COVERAGE. Check all that apply. I waive medical coverage for: ☐ Self ☐ Spouse ☐ Dependents

Reason for Waiving: ____

COMPLETE IF YOU HAVE OTHER COVERAGE. Insurance Company Name ______________________ Effective Date ________________

Policy No.____________________ Policyholder Name__________________________ Policyholder Date of Birth ______________

Insurance Company Address____ Policy covers ☐ Self ☐ Spouse ☐ Family

LAST NAME _____ FIRST NAME _____ MI _____

Are you eligible for Medicare? ☐ YES ☐ NO Part A - Effective Date _____ Part B - Effective Date _____
Is your spouse eligible for Medicare? ☐ YES ☐ NO Part A - Effective Date_____ Part B - Effective Date _____
Medicare HIC No._____ Is Medicare related to end-stage renal disease? ☐ YES ☐ NO
Is anyone listed on this application currently covered by other insurance? ☐ YES ☐ NO

Section E - Disclosure Acknowledgment

You must sign both places in Section E to be considered for coverage.

I understand that I am enrolling in a health care plan issued by Alliant Health Plans, Inc. (Alliant) that requires health care services be provided by participating providers. Failure to use a participating provider will result in reduced coverage or no coverage for services received, and I will be fully responsible for any and all costs not covered by Alliant. I have reviewed the list of participating providers which can be found on the website, AlliantPlans.com. I may also verify provider status by contacting Customer Service at (866) 403-2785. I understand the participation status of any provider may change from time to time and that it is my responsibility to verify participation of my health care provider with Alliant prior to receiving services. As required by the State of Georgia regulations, the following is a summary of the financial arrangements with health care providers who are participating in the Alliant network: 1) Hospital providers are paid according to a contract that includes per diems, case rates, and discounted fee for service arrangements depending on the specific services provided; 2) Physicians are paid either a discounted fee for services in accordance with a specific fee schedule or a predetermined set amount per member per month (capitation); 3) Laboratory services are provided through a capitation arrangement or a discounted fee for service in accordance with a specific fee schedule; 4) Other ancillary services including home health, skilled nursing, and hospice are paid on a contracted fee schedule with per diems or per visits amounts, or through a capitated per member per month flat fee.

Sign Here	Applicant or Legal Guardian Signature	Print Name	Date (MM/DD/YYYY)

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 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**: We are required by law to keep such data confidential. It will be seen only by our employees and authorized agents. This data may in certain circumstances be disclosed without your authorization. We may furnish such data to authorized federal or state agencies, consumer investigative service bureaus or others if part of our standard business practice or required by law. **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 need your personal information amended, corrected or deleted. If you wish to have a more detailed explanation of our information practices, please contact Customer Service.

CONDITIONS OF ENROLLMENT

I hereby apply for myself and/or my eligible family members for the medical coverage specified in the Contract between my Employer and Alliant. I understand and agree the effective date of coverage will be governed by the stipulations of the Employer Group Application and the Group Health Care Contract & Execution sheet under which this application is made. I understand membership will continue according to the terms of the contract between my Employer and Alliant. I hereby authorize my Employer to periodically deduct any charge due from me hereunder and to remit same to Alliant along with any contribution due from the Employer. I understand and agree that Alliant reserves the right to change the premium charges due for this coverage and to increase or decrease the benefits by giving sixty (60) days written notice to my Employer.

MEDICAL INFORMATION RELEASE AUTHORIZATION

PURPOSE: By signing this form, you will authorize the disclosure and use of the Protected Health Information described below for pre-enrollment underwriting or risk-rating of health insurance coverage for you, or to determine your eligibility for enrollment or benefits under a health plan. INFORMATION ALLIANT WILL USE and/or DISCLOSE: My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, employer or the Consumers Reporting Agency having information regarding myself and my dependents, including information concerning advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness and copies of all hospital or medical records, non-public personal health information, and any other non-medical information to share any and all such information with Alliant, its reinsurer or its legal representatives, and its affiliates.

Please initial below:

_____The information obtained by use of this authorization may be used by Alliant to determine eligibility. I declare that all statements and information made herein are complete and true to the best of my knowledge.

_____Any information obtained will not be released by Alliant to any person or organization except to reinsuring companies, or other persons or organizations performing health care operations or business or legal services in connection with any enrollment, claim or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report and I (we) may request a copy of the report.

_____Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.

EXPIRATION AND REVOCATION: A copy of this authorization is available to me or my legal representative upon writtWWWWen request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for two (2) years from the date below. I have the right to revoke this authorization at any time. To revoke the authorization, I understand that the revocation must be in writing to Alliant Health Plans, that it will not apply to information already released, that a revocation may adversely affect my enrollment, a claim or a pending insurance action, and the revocation will become effective after it is received by Alliant.

Sign Here	Applicant or Legal Guardian Signature	Print Name	Date (MM/DD/YYYY)

Notice of Non-Discrimination

Alliant Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Alliant Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Alliant Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact **Customer Service at (800) 811-4793**.

If you believe that Alliant Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Sabrina LeBeau, Compliance Officer, 1503 N. Tibbs Rd. Dalton, GA 30720, Ph: (706) 237-8802 or (888) 533-6507 ext 125, Fax: (706) 229-6289, Email: Compliance@AlliantPlans.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Sabrina LeBeau is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

English

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-811-4793 (TTY: 711).

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-811-4793 (TTY: 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-811-4793 (TTY: 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-811-4793 (TTY: 711)번으로 전화해 주십시 h 오.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-811-4793（TTY：711）。

ગુજરાતી (Gujarati)
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-811-4793 (TTY: 711).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-811-4793 (ATS : 711).

አማርኛ (Amharic)
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-811-4793 (መስማት ለተሳናቸው: 711).

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-811-4793 (TTY: 711) पर कॉल करें।

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-811-4793 (TTY: 711).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-811-4793 (телетайп: 711).

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-811-4793 (رقم هاتف الصم والبكم: 711 TTY).

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-811-4793 (TTY: 711).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-811-4793 (TTY: 711) تماس بگیرید.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-811-4793 (TTY: 711).

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-811-4793（TTY:711）まで、お電話にてご連絡ください。