Employer
Group
Enrollment Application

Employer Group Enrollment Application

The purpose of this form is for Alliant Health Plans to evaluate rating for the company's request for group insurance coverage.
Please answer all questions.
This form must be signed and dated by an officer of the company.

Please complete in blue or black ink only.

Section A: Company Information

Company name	Group administrator name	Employer tax ID no. (required)

Company street address	City	County	State	ZIP code
Billing address — If different from above	City	County	State	ZIP code

Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Government unit/agency ☐ Limited Liability Company (LLC)
☐ Labor union trust ☐ Other _____

SIC code — required only if applying for large group coverage	Type of business (be specific)(applies to large group)	Date business established

Company contact name	Title

Primary phone no.	Fax no.	Email address

Additional company contact name	Title

Primary phone no.	Fax no.	Email address

Does group have a cafeteria plan under IRS Section 125? ☐ Yes ☐ No

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal revenue Code Section 414? ☐ Yes ☐ No
If yes, please give the legal names, federal tax ID no. and number of employees employed by each.

_____

_____

_____

Open Enrollment

Our standard open enrollment period is at least 31 days before the Group's renewal date, which is held no more often than once in any 12 consecutive months. If you want a different open enrollment period, please enter the start and end dates.	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)

Section B: Application Type

☐ **New enrollment**	Requested effective date (MM/DD/YYYY)

Employer tax ID no. (required)

Section C: Type of Coverage

1. Medical Coverage — Please Check your selected product code(s): (Large Group and SHOP plans – enter plan choice in "other")

☐ 50001	☐ 50003	☐ 50004
☐ 50005	☐ 50006	☐ 50008
☐ 50009	Other:	Other:

Choose your medical contribution for each month — only one choice is allowed.

Contribution option 1: Traditional option — We will contribute (50% to 100%):_____% per employee and _____% per dependent (optional).

Contribution option 2 Percentage of plan option — We will contribute:_____% to _____plan)

2. *(Small Group Applicants ONLY)* **Dental Coverage — check all that apply**

Do you offer dental coverage to your employees?

☐ YES (if selected, please complete Pediatric Dental Opt-Out Form)

☐ NO

Section D: Eligibility

1. Total number of employees (including employed owners/officers): _____

2. Number of eligible full-time equivalent employees *(minimum 30 hours per week)* **:** _____

Are part-time employees to be covered? ☐ Yes ☐ No

3. Number of employees ENROLLING: _____

4. Number of eligible DECLINING employees: _____

5. Number of INELIGIBLE employees: _____

6. Will coverage be restricted to a certain classification of employees or employees working a certain number of hours per week? ☐ Yes ☐ No

If yes, please explain what class(es) or number of work hours are required (must be at least 30 hours)

_____

7. Probationary period/waiting period for new employees: (check only one)

☐ None ☐ First of month after hire date

☐ 30 days ☐ 60 days ☐ 90 days

8. New eligible enrollees will become effective on: (check one)

☐ First of month following completion of waiting period/probationary period

☐ Day following completion of waiting period/probationary periods *(required for 90 day waiting period)*

The "standard" effective date is first of the month following the waiting period/probationary period.

9. Under Medicare Secondary Payer rules, which one applies for your group? (check one)

☐ Medicare is primary (less than 20 employees)

☐ Alliant Health Plans is primary (20 or more employees)

Alliant Health Plans is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

10. Is your company currently subject to COBRA? *(Employed 20 or more total employees on at least 50% of the working days in the previous calendar year?)*

Check One: ☐ Yes ☐ No

11. Do you want Alliant to administer COBRA? (add'l fee may apply)

☐ Yes ☐ No

12. Does your business qualify as a small group?
(50 or fewer, Full-time equivalent employees)

☐ Yes ☐ No

Employer tax ID no. (required)

Section E: General Agreement

Please read this section carefully before signing the application.

Please check the box that applies:

To the best of our knowledge and belief, all information on this application is true and complete, and Alliant Health plans may rely on this application in deciding whether to provide coverage. If the application is not complete, Alliant Health Plans reserve(s) the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Alliant Health plans, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We understand that the premium rates calculated for the employer are contingent on the accuracy of eligibility data submitted on employees and covered dependents to Alliant Health Plans. Any misstatements on the employees' applications or failure to report new medical information prior to the employee's effective dates may result in a material change to the group's coverage or premium rates as of the effective date of the group coverage. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing by Alliant Health Plans and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Alliant Health Plans. The contract may be immediately cancelled for fraud.

If we decide to cancel our group coverage after coverage has been issued, we understand that the cancellation will become effective on the last day of the month in which Alliant Health Plans received the written notification of cancellation, and that no premiums will be refunded for any period between Alliant Health Plans' receipt of the notification and the last day of the month when the cancellation takes effect. If there are any premiums after the cancellation date, we understand that Alliant Health Plans will refund these premiums after 45 days from the premium deposit date.

- We agree to make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed; and,
- To maintain records and furnish to Alliant Health Plans or their designated agent(s), any information required in connection with administration of the insurance coverage; and, to provide notice of applicable conversion rights to eligible employees and eligible dependents; and,
- We will receive, on behalf of members, all notices delivered by Alliant Health Plans, and immediately forward such notices to persons involved, at their last known address, including certificates of coverage.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Sign here	Company officer signature X	Printed name	Title	Date (MM/DD/YYYY)

Employer tax ID no. (required)

Section F: Agent/Producer/Broker Certification

1. **I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.**
2. **I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.**
3. **I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Alliant Health Plans to attribute such additions or changes to me.**
4. **I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Alliant Health Plans reviews and approved the application and the employer receives a written notice from Alliant Health Plans.**
5. **I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Alliant Health Plans shall be paid to an agent/broker/producer not appointed/approved by Alliant Health Plans.**
6. **I have advised the client not to terminate any existing coverage until receiving written notification from Alliant Health Plans that the coverage being applied for by this application is accepted.**

Writing agent/producer/broker

Agency name		
Agent/producer/broker name		
Agent/producer/broker ID # (Tax ID)		
Street address	Street address 2	
City	State	ZIP code
Phone no.	Fax no.	
Email address		
Signature	Date (MM/DD/YYYY)	

Visit us on the web:

AlliantPlans.com

Alliant Health Plans
600 TownPark Lane
Suite LL-1000
Kennesaw, GA 30144

877-668-1015

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。

તમને વિના મૂલ્યે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. આરોગ્ય વીમા વ્યાપારબજાર વિશે દુભાષિયા સાથે ગુજરાતીમાં વાતચીત કરવા, કૉલ 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 የሚረዱት ሰው ስለAlliant Health Plans ጥያቄ ካላቸው፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸው። ከአስተርጓሚ ጋር ለመነጋገር፣ (800) 811-4793 ይደውሉ።

यदि आपके ,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 अधिकार है। ककसी भाषषए से बात करने के लिए, (800) 811-4793 पर कॉ करें।

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.

إذا كان لديك أو لدى شخص تقدم له المساعدة أسئلة بخصوص Alliant Health Plans، فلديك الحق في الحصول على المساعدة والمعلومات اللازمة بلغتك دون أي تكلفة. للتحدث مع مترجم فوري، اتصل بالرقم (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 آپ ، یا وہ شخص جس کی آپ مدد کر رہے ہیں ، کو Alliant Health Plans، کے بارے میں سوالات درکار ہیں تو آپ کو حق حاصل ہے کہ آپ اپنی زبان میں بغیر کسی لاگت کے مدد اور معلومات حاصل کریں۔ ترجمان سے بات کرنے کے لیے (800) 811-4793. پر کال کریں

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。

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).

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 cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Alliant Health Plans tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Alliant Health Plans 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Alliant Health Plans 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視 任何人。

Alliant Health Plans લાગુ પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અશક્તતા અથવા લિંગના આધારે ભેદભાવ રાખવામાં આવતો નથી.

Alliant Health Plans respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Alliant Health Plans የፌደራል ሲቪል መብቶችን መብት የሚያከብር ሲሆን ሰዎችን በዘር፡ በቆዳ ቀለም፣ በዘር ሃረግ፣ በእድሜ፣ በአካል ጉዳት ወይም በጾታ ማንኛውንም ሰው አያገልም።

Alliant Health Plans लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

Alliant Health Plans konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

Alliant Health Plans соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Alliant Health Plans يلتزم الأصل الوطني أو السن أو الإعاقة أو الجنس.

Alliant Health Plans cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base naraça, cor, nacionalidade, idade, deficiência ou sexo.

Alliant Health Plans و کند می تبعیت مربوطه فدرال مدنی حقوق قوانین از هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، ملیتی، اصلیت یا ناتوانی سن، جنسیت شود نمی قایل افراد.

Alliant Health Plans erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Alliant Health Plansは適用される連邦公民権法を遵守し、人種、肌の色、出身国、 年齢、障害または性別 に基づく差別をいたしません。