EMPLOYER GROUP ENROLLMENT APPLICATION

This Application is utilized to evaluate an employer group's request for group insurance coverage. Please answer all questions. This form must be signed and dated by an Officer of the Employer Group.

Please complete electronically or in blue or black ink only.

Section A: Employer Group

Employer Group Name	Employer Group Administrator Name	Employer Group Tax ID no. (required)

Street Address	City	County	State	Zip Code
Billing Address (if different from above)	City	County	State	Zip Code

Employer Group 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	Specific Type of Business *(applies to Large Group)*	Date of Establishment

Employer Group Contact Name		Title
Primary Phone Number	Fax Number	Email Address
Secondary Employer Group Contact Name		Title
Primary Phone Number	Fax Number	Email Address

Section B: Administrative Dates

Open Enrollment - The standard open enrollment period is no less than 31 days before the employer group's renewal date, which is held no more often than once in any 12 consecutive months. If you prefer a different open enrollment period than the standard described, please enter the start and end dates.	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
New Enrollment - Please enter the date on which you would like for coverage to begin.	Requested Effective Date (MM/DD/YYYY)	

Section C: Type of Coverage

1. **Medical Coverage**- Please indicate your selected medical plan code(s): _____
_____

2**. Prescription Coverage** - Please indicate your selected prescription plan code(s): _____
(If applicable - i.e. large group Applications may select specific prescriptions coverage options)

3. **Dental Coverage** - Please indicate your selected dental plan code (if any): _____

Employer Group Tax ID no. (required)

Section D: Eligibility

Full Time Equivalent Employee (FTE): an employee who works an average of at least 30 hours per week for more than 120 days in a year.
Average Number of Employees: average number of employees employed on business days in the prior calendar year including full time, part time and seasonal.
Large Group: a group with 51 or more full time equivalent (FTE) employees.
Small Group: a group with 50 or fewer full time equivalent (FTE) employees.

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

2. Number of eligible FTEs (minimum 30 hours per week): _____

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

3. Average number of employees: _____

4. The applicant qualifies as
   ☐ Large Group
   ☐ Small Group

5. Number of employees ENROLLING: _____

6. Number of eligible employees DECLINING: _____

7. Number of INELIGIBLE employees: _____

8. 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).
   _____

Waiting period for new employees: (please check **one**)
☐ Date of Hire (DOH) ☐ First of month after DOH ☐ 30 days after DOH ☐ 60 days after DOH ☐ 90 days after DOH

New eligible enrollees will become effective on: (check one)
☐ First of month following completion of waiting period (cannot be elected if choosing a 90 day waiting period).
☐ Day following completion of waiting period (required for 90 day waiting period).

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

Medicare Secondary Payer rules dictate that for employer 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, Alliant Health Plans is the primary payer. For employer groups with fewer than 20 total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year, Medicare is the primary payer.
For this employer group, the primary payer will be: ☐ Alliant Health Plans ☐ Medicare

Employer groups who employ 20 or more total employees on at least 50% of the working days in the previous calendar year are subject to COBRA.
The employer group is subject to COBRA ☐ Yes ☐ No
The employer group would like Alliant Health Plans to administer COBRA (additional fees may apply) ☐ Yes ☐ No

Alliant Health Plans, Inc. ("AHP"), through itself and its parent organization Health One Alliance, LLC ("HOA"), provides administration, marketing, and support services for Serventy Insurance Corporation, Inc. ("Serventy") and AHP. By enrolling employees in AHP or Serventy programs, you are authorizing AHP or its affiliates to maintain a centralized database of demographic and product information to administer services that support their access to products and services. If there are updates to their personal information received by AHP or Serventy, that same information will be disclosed and updated to the other entity through this centralized database. The purpose of this disclosure of information between AHP and Serventy shall be to update their demographic, payment, or product information.

Employees may revoke the authorization by providing written notice to Alliant Health Plans, ATTN: PHI Forms, PO BOX 1128, Dalton Georgia 30722, or email PHI@AlliantPlans.com. Upon receipt of a revocation, HOA and AHP shall not update their data within the Serventy system, and their account will be separated. Any information used or disclosed before the revocation shall remain in the combined databases.

Sign Here	Employer Group Officer Signature	Printed Name	Title	Date (MM/DD/YYYY)

Employer Group Tax ID no. (required)

Section E: General Agreement

Please read this section carefully before signing the Application.

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 full first month's premium and this Application is accepted. We understand that the premium rates calculated for the employer group 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 employees' effective dates may result in a material change to the employer 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 broker 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 canceled 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,
  - Eligible Employee
    - An active employee of the Employer Group 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
    - Eligible employee's spouse, or child(ren) under age 26, which includes a newborn, natural child, or a child placed with the eligible employee for adoption, a stepchild or any other child for whom the eligible 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 incapacitated dependent (unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity, as defined by applicable State or Federal law that began prior to the child reaching the age limit. Coverage may be obtained for the dependent who is beyond the age limit at the initial enrollment if the eligible employee provides proof of incapacitation and dependence at the time of enrollment. (The eligible 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.
- To maintain records and furnish to Alliant Health Plans or their designated broker(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	Employer Group Officer Signature	Printed Name	Title	Date (MM/DD/YYYY)

Employer Group Tax ID no. (required)

Section F: 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 employer group 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 broker and am receiving commissions for the submission of this employer group. No portion of my commission payments from Alliant Health Plans shall be paid to a broker not appointed/approved by Alliant Health Plans.
6. I have advised the employer group 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 Broker

Agency Name	Broker Name	Agency Tax ID no. (required)
Street Address	Street Address 2	
City	State	Zip Code
Phone Number	Fax Number	
Email Address		
Signature		Date (MM/DD/YYYY)

Auto Pay

To ensure premiums are paid in a timely manner, Alliant Health Plans offers Auto Pay.
You may enroll by completing the Auto Pay Form, which can also be found on AlliantPlans.com.

BY ACCEPTING THE TERMS OF THIS AGREEMENT, YOU AGREE TO COMMUNICATE AND TO RECEIVE COMMUNICATIONS VIA EMAIL OR VIA TEXT. BY COMMUNICATING VIA EMAIL AND BY VOLUNTARILY PROVIDING YOUR CELL PHONE NUMBER YOU AGREE AND ACKNOWLEDGE THAT YOU UNDERSTAND THAT EMAIL AND TEXT MESSAGE IS NOT A SECURE FORM OF COMMUNICATION AND MAY BE SUBJECT TO UNAUTHORIZED USE OR ACCESS BY THIRD-PARTIES. BY SENDING OR RECEIVING EMAIL OR TEXT COMMUNICATIONS, YOU AGREE TO ASSUME THE RISK OF AN UNAUTHORIZED ACCESS TO THE EMAIL TEXT IN ORDER TO HAVE THE BENEFIT OF EMAIL OR TEXT COMMUNICATIONS RELATED TO THESE SERVICES.

Sign Here	Employer Group Officer Signature	Printed Name	Title	Date (MM/DD/YYYY)

Employer Group Tax ID no. (required)

THANK YOU FOR APPLYING

Please include all necessary materials when submitting this Application.

Mail this Application to:
Alliant Health Plans
PO Box 1128
Dalton, GA 30722

or

Fax to:
(706) 229-4897

For more information, visit us on the web at: AlliantPlans.com

(866) 403-2785
SimpleCare@AlliantPlans.com