GROUP (Short Medical) ENROLLMENT APPLICATION

[Print in black ink]

DATE OF EMPLOYMENT ___-___-____

EFFECTIVE DATE OF COVERAGE ___-___-____

☐ New Enrollment
☐ Add Dependent
☐ Open Enrollment

Qualifying Event
(Select from below)
☐ Marriage (License Req'd)
☐ Divorce (Decree Req'd)
☐ Birth / Adoption
☐ Loss of Coverage
Creditable Coverage Cert. Req'd
☐ Other: _____

GROUP NUMBER A _____ | DEPT CODE _____ | COMPANY NAME _____

EMPLOYEE LAST NAME _____ FIRST _____ MI _____

EMPLOYEE HOME ADDRESS _____

CITY _____ | STATE _____ | ZIP+ 4 CODE _____

HOME PHONE ___-___-____ | BUSINESS PHONE ___-___-____ | COUNTY: (Where you live) _____

EMAIL ADDRESS: _____

Do you wish to receive all member material by E-mail instead of hard-copy? ☐ YES ☐ NO

COVERAGE APPLIED FOR:
PPO: _____
HMO: _____
Rx Plan: _____
HDHP: _____

EMPLOYMENT STATUS:
☐ Active ☐ Leave of Absence
☐ Retired ☐ Disabled
☐ COBRA: Start Date: _____
Reason on COBRA: _____

COMPANY DIV/DEPT _____ ☐ Hourly ☐ Salary

WAIVER OF COVERAGE: Complete ONLY if Waiving Coverage

☐ **I waive medical coverage for:** ☐ Self (and Dependents) ☐ Spouse ☐ Dependents

State Reason for Waiving Coverage: _____

SIGNATURE _____ **DATE** _____

NOTE: Be sure to PRINT your full name in the top section

Complete the following on each person applying for coverage:

EMPLOYEE

LAST NAME _____ | FIRST _____ | MI _____ | DATE OF BIRTH ___-___-____

SOCIAL SECURITY NO. ___-___-____ | Height: _____ | Weight: _____

SEX ☐ MALE ☐ FEMALE | DISABLED? ☐ YES ☐ NO

SPOUSE

LAST NAME _____ | FIRST _____ | MI _____ | DATE OF BIRTH ___-___-____

SOCIAL SECURITY NO. ___-___-____ | Height: _____ | Weight: _____

SEX ☐ MALE ☐ FEMALE | DISABLED? ☐ YES ☐ NO

CHILD

LAST NAME _____ | FIRST _____ | MI _____ | DATE OF BIRTH ___-___-____

SOCIAL SECURITY NO. ___-___-____ | Height: _____ | Weight: _____

SEX ☐ MALE ☐ FEMALE | Is this is a "Step-Child"? ☐ YES ☐ NO | DISABLED? ☐ YES ☐ NO

CHILD

LAST NAME	FIRST	MI	DATE OF BIRTH

SOCIAL SECURITY NO. ___-___-____ Height: Weight:

SEX ☐ MALE ☐ FEMALE | Is this is a "Step-Child"? ☐ YES ☐ NO | DISABLED? ☐ YES ☐ NO

CHILD

LAST NAME	FIRST	MI	DATE OF BIRTH

SOCIAL SECURITY NO. ___-___-____ Height: Weight:

SEX ☐ MALE ☐ FEMALE | Is this is a "Step-Child"? ☐ YES ☐ NO | DISABLED? ☐ YES ☐ NO

Medical Information

HEALTH QUESTIONS: All of the following questions must be answered with respect to **each person** applying for coverage.
Answer YES or NO for each question

SECTION A

Yes	No	
☐	☐	a. IN THE LAST 6 MONTHS – have you (or any eligible dependents) incurred claims in excess of $2,500?
☐	☐	b. Is any person applying for coverage receiving treatment, taking medication or been advised of a condition that will require attention IN THE NEXT 6 MONTHS?
☐	☐	c. Has any person applying for coverage been diagnosed or tested for Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex by a Physician or member of the medical profession?
☐	☐	d. IN THE LAST 6 MONTHS - has any person applying for coverage been diagnosed or had treatment for any of the following: Cancer/Tumor, Diabetes, Health/Blood/Vascular Disorder, Kidney Disorder, Liver Disorder, Respiratory/Lung Disorder, Stroke, System Lupus/Multiple Sclerosis, Transplant of any kind?

COMPLETE THIS SECTION IF ANY QUESTIONS WERE ANSWERED "YES" IN SECTION A ABOVE

Person Treated	Condition/ Diagnosis	Medication Prescribed	Treatment Dates		Name and Address of Attending Physician
			From	To	

If you need more room, please attach additional information to this application. Be sure to include YOUR full name in case it gets separated.

LAST NAME	FIRST	MIDDLE

Will you or any dependents have any other medical insurance, including Medicare ☐ YES ☐ NO

Who is covered by this other insurance? ☐ Self ☐ Spouse ☐ Child(ren) Only ☐ Family

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#: | | | | | | | | | | | |

Is Medicare coverage related to end-stage renal disease? ☐ YES ☐ NO

DISCLOSURE ACKNOWLEDGEMENT: I understand that I am enrolling in a health care plan issued by Alliant Health Plans ("AHP") 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 that I receive, and I will be fully responsible for any and all costs not covered by AHP. I have reviewed the list of participating providers which can be found on AHP's web site, www.AlliantPlans.com. I may also verify provider status by contacting Customer Service at the number listed on my member ID card. I understand that 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 AHP 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 AHP 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 services 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.

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 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 the Customer Service Department.

YOU MUST PROVIDE YOUR SIGNATURE HERE AND ON PAGE 4 TO BE CONSIDERED FOR COVERAGE

APPLICANT or LEGAL GUARDIAN'S SIGNATURE _____ **DATE SIGNED** _____

PRINT NAME _____

LAST NAME	FIRST	MIDDLE

IF YOU ARE APPLYING FOR COVERAGE AND PORTABILITY RULES APPLY, PLEASE FURNISH PROOF OF YOUR PRIOR COVERAGE (Creditable Coverage Certificate) WITH THIS APPLICATION

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 Health Plans (hereinafter referred to as the Company). I understand and agree that 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 that membership will continue according to the terms of the contract between my Employer and the Company. I hereby authorize my Employer to periodically deduct any charge due from me hereunder and to remit same to the Company along with any contribution due from the Employer. I understand and agree that the Company reserves the right to change the subscription 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 WE 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 the Company, its reinsurer or its legal representatives, and its affiliates.

* The information obtained by use of this authorization may be used by Alliant Health Plans to determine eligibility I declare that all statements and information made hereon are complete and true to the best of my knowledge.
* Any information obtained will not be released by Alliant Health Plans 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 application, 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 written requst. 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 shown 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 application, a claim or a pending insurance action; and the revocation will become effective after it is received by Alliant Health Plans.

YOU MUST PROVIDE YOUR SIGNATURE HERE AND ON PAGE 3 TO BE CONSIDERED FOR COVERAGE

APPLICANT or LEGAL GUARDIAN'S SIGNATURE_____ **DATE SIGNED**_____

PRINT NAME_____

LAST NAME	FIRST	MIDDLE

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 Sabrina LeBeau.

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

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 የሚያግዙት ግለሰብ፣ ስለAlliant Health Plans ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለማነጋገር፣ (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.

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.

اگر شما، يا کسی که شما به او کمک می کنيد، سوال در مورد Alliant Health Plans، داشته باشيد حق اين را داريد که کمک و اطلاعات 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。

TTY/TDD

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