SMALL 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** _____

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.

Section A - Coverage Information

Employee Name_____ Date of Hire _____

Effective Date _____

Employment Status: ☐ Active ☐ Leave of Absence ☐ Retired ☐ Disabled

☐ COBRA Date_____ Reason_____

Application 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 all policy documents via your email address above? ☐ Yes ☐ No			

Continue to next page

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 (866) 403-2785.

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 (866) 403 hasta 2785.

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

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

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

Section D - 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?

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 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 expected cancellation date? _____

Continue to next page

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 (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 Aliant's website, AlliantPlans.com. I may also verify provider status by contacting Customer Service at the number listed on my member ID card. 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.

***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 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 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 application, 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)

Section F: 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):

- 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 the Georgia Department of Human Resources) 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.
- 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 (866) 403-2785.**

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 Agreement 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 signature	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 G: EMPLOYEE DECLINING Information

Last Name	First Name	MI	EE ID or Last 4-digits of SSN

Sign Here	Applicant signature	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 you 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 (866) 403-2785.