INDIVIDUAL FAMILY AND CHILD-ONLY

ENROLLMENT AND CHANGE IN COVERAGE FORM

INSTRUCTIONS

- You will need all applicants' social security numbers, dates of birth and addresses.
- Print all answers in **blue or black** ink only. Pencil will not be accepted. Fill in the boxes [▫] like this --> ■
- Correct errors by crossing out incorrect information and initialing next to the correct information.
- The Primary Applicant must personally sign the enrollment form. Spouses or dependents over the age of 17 must personally sign the enrollment form.
- Your initial premium payment must be received before the requested coverage effective date to use your health benefits. You can pay for your first month's premium by credit card, one-time bank draft or check.

INDIVIDUAL FAMILY/ PLAN APPLICATION

OPEN ENROLLMENT

Open Enrollment is November 1 through December 15. During Open Enrollment, you may apply for coverage, change plans, or add dependents.

SPECIAL ENROLLMENT PERIOD (SEP)

Applications must be received within 60 days of the Qualifying Life Event (QLE) in order to qualify for the Special Enrollment Period (SEP). You must provide supporting documentation of your QLE.

QUALIFYING LIFE EVENTS

Please check ONE:

- □ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- □ Involuntary loss of employer sponsored health insurance
- □ Loss of coverage for dependent child who has reached age 26
- □ Newly eligible for an Individual Coverage Health Reimbursement Arrangement.
- □ Marriage/Divorce
- □ Adoption or placement for adoption or appointment of guardianship
- □ Birth of a dependent child
- □ OTHER (please describe): _____
- □ Exhaustion of COBRA

Please provide the date of the QLE (MM/DD/YYYY): _____

NOTE: QLEs require supporting documents (e.g., Marriage Certificate, Divorce Decree, Adoption Certificate, Certificate of Creditable Coverage, etc.). Attach your documentation to this Application.

Only the most common QLEs are mentioned on this form, this is not a complete list. Call Customer Service at (866) 403-2785.

CHILD-ONLY POLICY (UNDER 18) APPLICATION

All Instructions above plus:

- Check Child Only Application box and complete Section C for the child/subscriber.
- The child's legal guardian must complete the Guardian Information Section.
- The legal guardian must sign Signature Box 1.

Section A - Coverage Information

APPLICATION TYPE (select one)

- □ New Coverage
- □ Change policy coverage
  Current Member ID: _____
- □ Add dependent(s) to current coverage
  Current Member ID: _____

Send your enrollment form:	*Mail:* *Alliant Health Plans* *PO Box 2088* *Dalton, GA 30722*	*Email:* *SoloCare@Alliantplans.com*

Section B - Enrollment Plan Election (Plan Name and Deductible/Coinsurance Options)

Please provide the PLAN Name and ID: (example: SoloCare Silver Copay)

Section C - Primary Applicant Information

Last Name	First Name	MI	Gender ☐ M ☐ F
Social Security Number (SSN)	No SSN? Check one: ☐ Newborn ☐ Green Card ☐ Passport List Number:		Date of Birth (MM/DD/YYYY)

Address	City	State	ZIP	County
Mailing Address	City	State	ZIP	County

Phone Number ( )	Cell Phone Number ( )	Email

Within the past 6 months, have you used tobacco? (4 or more times per week on average) ☐ Yes ☐ No

☐ Check here if this is a CHILD ONLY APPLICATION (under 18 years of age)

Guardian Information

Last Name	First Name	MI
Address (if different than above)		

City	State	ZIP	County

Communication Preference

What is your preferred written language? ☐ English ☐ Spanish	What is your preferred spoken language? ☐ English ☐ Spanish

Section D - Spouse to be Covered Information

Last Name	First Name	MI	Gender ☐ M ☐ F
Social Security Number	Date of Birth (MM/DD/YYYY)	Within the past 6 months, have you used tobacco? (4 or more times per week on average) ☐ Yes ☐ No	

Section E - Child Dependents to be Covered (All fields are required. Please attach a separate sheet if necessary.)

List information for all additional child dependents to be covered under this coverage. An Eligible Dependent may be your child(ren), or your spouse's child(ren), under age 26.

Last Name	First Name	MI	Gender ☐ M ☐ F	Social Security Number	Tobacco User ☐ Y ☐ N
Phone Number			Date of Birth (MM/DD/YYYY)		
Mailing Address (if different from Applicant)			Email		

Section D - Child Dependents to be Covered (continued)

Last Name	First Name	MI	Gender M ☐ F	Social Security Number	Tobacco User ☐ Y ☐ N
Phone Number			Date of Birth (MM/DD/YYYY)		
Mailing Address (if different from Applicant)			Email		
Last Name	First Name	MI	Gender ☐ M ☐ F	Social Security Number	Tobacco User ☐ Y ☐ N
Phone Number			Date of Birth (MM/DD/YYYY)		
Mailing Address (if different from Applicant)			Email		
Last Name	First Name	MI	Gender ☐ M ☐ F	Social Security Number	Tobacco User ☐ Y ☐ N
Phone Number			Date of Birth (MM/DD/YYYY)		
Mailing Address (if different from Applicant)			Email		

Are all Applicants listed on this Application legal residents of the United States and residents of the state in which you are applying for coverage? ☐ Yes ☐ No

Are all Applicants United States citizens, nationals or lawfully present non-citizens? ☐ Yes ☐ No

Section F - Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, who? _____

Note: SoloCare is not a supplemental plan. If you are covered by Medicare, please consult with a licensed health insurance broker on your options. If you are currently enrolled in Medicare, please contact a SoloCare representative at SoloCare@AlliantPlans.com or (866) 403-2785.

Conditional Receipt
THIS RECEIPT DOES NOT PROVIDE ANY COVERAGE UNTIL ALL THE TERMS AND CONDITIONS LISTED BELOW ARE MET.

Alliant has received from the named Applicant an advance deposit equal to the first month's premium together with an application for designated health insurance coverage. Such payment is accepted subject to the following conditions:

Subject to the provisions of the contract, the coverage applied for will be effective from, and the contract date as of, the day following acceptance by Alliant, unless otherwise specifically stated, provided that the payment evidenced by this receipt is the full first month's premium and provided that Alliant determines that as of the date of the Application all proposed covered persons were acceptable for coverage and for the benefits applied for. If the Application is not approved by Alliant said Plan shall incur no liability and the payment evidenced by this receipt will be refunded to the Applicant. No one has the authority to waive or modify any of the terms or conditions of this receipt.

If you do not receive a contract within 60 days, please contact Customer Service at (866) 403-2785.

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 broker 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

Section G: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

- 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 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 brokers 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 brokers may contact me using an auto-dialer.
- **I AGREE TO COMMUNICATE AND TO RECEIVE COMMUNICATIONS VIA EMAIL OR VIA TEXT FROM HEALTH ONE ALLIANCE, INC. AND ITS SUBSIDIARIES AND AFFILIATES.** BY COMMUNICATING VIA EMAIL AND BY VOLUNTARILY PROVIDING MY CELL PHONE NUMBER I AGREE AND ACKNOWLEDGE THAT I UNDERSTAND THAT EMAIL AND TEXT MESSAGE ARE 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, I 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.

  □ OPT OUT - I DO NOT WANT TO COMMUNICATE AND TO RECEIVE COMMUNICATIONS VIA EMAIL OR VIA TEXT FROM HEALTHONE, INC AND ITS SUBSIDIARIES AND AFFILIATES.
- I understand that although Alliant Health Plans requires payment with my Application, sending my initial premium with this Application, and the receipt of my payment by Alliant, does not mean that coverage has been approved. I am applying for the coverage selected on this Application. I understand that, to the extent permitted by law, Alliant reserves the right to accept or decline this Application, and that no right whatsoever is created by this Application. I understand that if my Application is denied, any premium paid will be refunded.
- Eligible Dependents include the subscriber's spouse and all children until attaining age 26. Children include natural children, legally adopted children and stepchildren. Also included are your children (or children of your spouse) for whom you have legal responsibility resulting from a valid court decree. Foster children whom you expect to raise

- to adulthood and who live with you in a regular parent-child relationship are considered children. However, for the purposes of this contract, a parent-child relationship does not exist between you and a foster child if one of both of the child's natural parents also live with you. In addition, Alliant does not consider a welfare placement of a foster as a dependent, as long as the welfare agency provides all or part of the child's support.
- Incapacitated Dependent: A dependent in which the Applicant or the Applicant's spouse is the court-appointed legal guardian; and the dependent is mentally or physically incapable of earning a living as determined by the Georgia Department of Human Resources, and the dependent is chiefly dependent upon the Applicant for support and maintenance, provided that the onset of such incapacity occurred before the dependent was 26.
- I am responsible to timely notify Alliant of any change that would make me or any dependent ineligible for coverage.
- I understand Alliant may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Alliant automatic debit process and will only occur each time I send a check to Alliant Health Plans. I understand that Alliant may, at its discretion, attempt to process the payment again within 30 days, and agree to an additional $35 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
- 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 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 your access to products and services. If there are updates to your 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 your demographic, payment, or product information. You 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 your revocation, HOA and AHP shall not update your data within the Serventy system, and your account will be separated. Any information used or disclosed before the revocation shall remain in the combined databases.
- I acknowledge that I have read the Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this Application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Alliant in accepting this Application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this Application may result in denial of benefits, rescission or cancellation of my coverage(s).

I give this authorization for and on behalf of any Eligible Dependents and myself. I am acting as their broker and representative.

I hereby acknowledge that Alliant 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.

Sign Here	Signature of Applicant* or Legal Representative	Date (MM/DD/YYYY)
	Signature of Spouse or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative	Date (MM/DD/YYYY)
	Signature of Dependent Child(ren) age 18 or over (if to be covered)	Date (MM/DD/YYYY)
	Signature of Dependent Child(ren) age 18 or over (if to be covered)	Date (MM/DD/YYYY)

** (or Custodial Parent or Guardian signature if Applicant is under age 18)*

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 H: Broker Certification

This section should be completed by your Alliant Health Plans-appointed broker (if applicable).

Did you see the proposed subscriber (and spouse, if applying) at the time this Application was executed?
□ Yes □ No

If **NO**, please explain: _____

I certify to the best of my knowledge and belief, the responses herein are accurate.

Broker Signature		Date
Broker Name		Broker Street Address/Suite No./Personal Mail Box (PMB) No.
Broker NPN	Broker Parent TIN	City State ZIP
Broker Phone	Broker Fax	Broker Email

Authorization for Use of Protected Health Information

By signing below: I authorize Alliant Health Plans, or a 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	Printed Name of Applicant* or Legal Representative	Signature of Applicant* or Legal Representative	Date (MM/DD/YYYY)
	Printed Name of Spouse or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative	Signature of Spouse or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative	Date (MM/DD/YYYY)
	Printed Name of Dependent Child(ren) age 18 or over (if to be covered)	Signature of Dependent Child(ren) age 18 or over (if to be covered)	Date (MM/DD/YYYY)

If listed on your Application or change form, your spouse and each dependent child age 18 or over must sign above. If a legal representative signs on behalf of the Applicant or spouse, a copy of the legal representative's authority must be attached to the Application. A photocopy of this form will be as valid as the original. You or an authorized representative have the right to receive a copy of this Authorization upon request.

PAYMENT OPTIONS - SOLOCARE ENROLLMENT

Enrollment Payment

Choose from the following payment options for the first month/effectuary payment:

☐ Auto Pay (must be recieved by the 14th of the month priot to the effective date)

☐ Debit/Credit

☐ Debit/Credit for first payment and enroll in Auto Pay

Credit / Debit Card

☐ **Credit / Debit Card** – As a convenience to me, I request and authorize Alliant Health Plans to charge my card for a **one time** initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and removing dependents, moving my residence changing coverage, and/or changes made by Alliant Health Plans of which I am notified pursuant to my plan/policy. I agree that Alliant Health Plans shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, Alliant Health Plans shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

Choose your card type: ☐ Visa ☐ Mastercard			
Card Number	**Expiration Date**	**Security Code (3-digit)**	
Card Billing Address	**City**	**ZIP**	
Cardholder Name (as it appears on the card - PLEASE PRINT)	**Cardholder Signature** (as it appears on the card)		**Date**

Check

☐ **Mail a Paper Check -** When you provide a paper check as payment, you authorize Alliant Health Plans either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Alliant Health Plans uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval, and you will not receive your check back from your financial institution.

Please mail your check to the following address or attach to this Application:

Alliant Health Plans
P.O. Box 2088
Dalton, GA 3072

Attach check here

Continue to next page

AUTO PAY

FOR GROUPS & INDIVIDUALS

Please type or print in black/blue ink only. Incomplete and/or illegible fields and signatures may cause a delay to your enrollment.
Group representatives should complete sections A, C, D, & E. Individual members should complete sections A, B, D, & E.

Section A: Type of Authorization

Please check one: ☐ NEW AUTO PAY ENROLLMENT ☐ CHANGE AUTO PAY ENROLLMENT ☐ CANCEL AUTO PAY ENROLLMENT

Section B: Individual Subscriber Information *(to be completed by Individuals ONLY)*

First Name: _____ **MI:** _____ **Last Name:** _____

Subscriber ID # (as shown on ID card)**:** _____

Phone Number: _____ **Email**: _____

Section C: Group Information *(to be completed by Groups ONLY)*

Group Name: _____

Group Representative: _____ **Group #** (as shown on ID card): _____

Phone Number: _____ **Email:** _____

Section D: Financial Institution Information

Account Holder Full Name	**Account Holder Billing Address**
Financial Institution Name	**Type of Account (check one)** ☐ CHECKING ☐ SAVINGS **A voided check is NOT required.**
Financial Institution Routing/Transit Number	**Financial Institution Account Number**

Section E: Agreement and Signature

I (we) hereby authorize Alliant Health Plans to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I am (we are) responsible for the validity of the information on this form. If Alliant Health Plans erroneously deposits funds into my (our) account, I (we) authorize Alliant Health Plans to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay cycle. I (we) understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of a transaction being rejected for Non-Sufficient Funds (NSF), I (we) understand that Alliant Health Plans may at its discretion attempt to process the payment again within 30 days, and agree to an additional $35 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I (we) understand that Alliant Health Plans will cancel an auto draft enrollment that fails for two consecutive months.

I (we) agree to comply with all certification requirements of Alliant Health Plans and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by Alliant Health Plans or its authorized affiliate(s) or subcontractor(s). I (we) understand that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through Alliant Health Plans in accordance with applicable state and federal laws, rules and regulations.

Auto Pay Date: 25th of the Month (or the following business day)

Please note: Your payment will be processed on the 25th of each month, or the following business day, for the next month's premium payment. This form must be received by the 15th of the month for Auto Pay to be setup on the aforementioned schedule. Until your auto pay is setup, you will need to make your premium payment by mailing a check, visiting the website or calling the phone IVR payment system.

Account Holder Signature: _____ Date: _____

Printed Name: _____ Relation to Subscriber: _____

Subscriber Signature: _____ Date: _____

Printed Name: _____ Email Address: _____

RETURN THIS FORM TO:

Alliant Health Plans
PO BOX 2088
Dalton, GA 30722

Fax: (706) 229-6287
Email: AutoPay@Alliantplans.com