EMPLOYER GROUP ENROLLMENT APPLICATION

This Application is utilized to evaluate an employer group's request for group 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 ________________________________

Employer Group Contact Name	Title	Date of Establishment

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 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)

Employer 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

A. Number of full-time employees working on average 30 hours or more a week (or 130 hours a month) for more than 120 days a year (even if they are not eligible or enrolling for health coverage).	
B. Number of part-time employees, who worked on average less than 30 hours a week, but more than 120 days a year. (Add up the total number of hours worked in a week by part-time employees and divide by 30.) **Example:** 10 employees working 20 hours a week: 200 + 30 = 6.66 = 6 (rounding down to the nearest whole number)	
C. Total number of FTEs = A + B.	
D. Did your business have 20 or more total employees during at least 50% of the working days in the previous calendar year?	Yes No
E. Did your employee have at least 20 employees (including part-time, seasonal, temporary, owners, partners, and officers) for at lest 20 weeks in the prior years?	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)

Auto Pay

To ensure timely payments, Alliant Health Plans requires 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 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. We understand that the costs 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 costs 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 refunds are available 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 deposits from the Plan Sponsor after the cancellation date, we understand that a refund will occur after 45 days from the deposit date; after applying applicable charges.

- We agree to make the 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 Plan Sponsor 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 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.
- 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 and denial of coverage.

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

Employer Tax ID no. (required)

Section F: 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 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

Sign Here	Signature	Date (MM/DD/YYYY)

Mail this Application to:

Alliant Health Plans
PO Box 1128
Dalton, GA 30722

or

Fax to:

(706) 229-4897