EMPLOYEE ENROLLMENT FORM WITH MEDICAL

Use this form to Enroll or Waive Coverage (Print in black or blue ink)

EMPLOYER NAME _____ **GROUP ID** _____ **DIV** _____ **PLAN** _____

Section A - Coverage Information

Employee Name _____ Effective Date of Coverage _____

Employment Status ☐ Active ☐ Leave of Absence ☐ Retired ☐ Disabled ☐ COBRA Date_____Reason _____

Enrollment Type ☐ New Enrollment Date of Hire _____ ☐ Open Enrollment ☐ Waiving Coverage

Qualifying Life Event ***DOCUMENTATION REQUIRED**

☐ Marriage* ☐ Divorce* ☐ Birth / Adoption* ☐ Loss of Coverage*

☐ Other _____ Event Date (MM/DD/YYYY)_____

Section B - Waiving Coverage - Complete Only If Waiving Coverage

Check all that apply. I waive medical coverage for: ☐ Self ☐ Spouse ☐ Dependents

Reason for Waiving: _____

Section C - Other Coverage

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

Last Name _____ First Name _____ MI _____

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 No. _____ Is Medicare related to end-stage renal disease? ☐ YES ☐ NO

Is anyone listed on this application currently covered by other insurance? ☐ YES ☐ NO

Section D - 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 policy documents via your email address above? ☐ Yes ☐ No			

Section E - 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	Is this a "Step-Child"? ☐ Y ☐ N
Social Security Number	Date of Birth (MM/DD/YYYY)	Gender ☐ M ☐ F	Disabled? ☐ Y ☐ N

Child Information

Last Name	First Name	MI	Is this a "Step-Child"? ☐ Y ☐ N
Social Security Number	Date of Birth (MM/DD/YYYY)	Gender ☐ M ☐ F	Disabled? ☐ Y ☐ N

Section E - Dependent Information - continued

Child Information

Last Name	First Name	MI	Is this a "Step-Child"? ☐ Y ☐ N
Social Security Number	Date of Birth (MM/DD/YYYY)	Gender ☐ M ☐ F	Disabled? ☐ Y ☐ N

Section F - Medical History

HEALTH QUESTIONS: All of the following questions must be answered with respect to **each person** applying for coverage.
Has anyone listed on this application in the past 5 years, had medical advice, treatment or do you know of health issues in regard to the following? This information will be used to evaluate medical risk, not eligibility for coverage.

Yes No Check YES or NO for each question

☐ ☐ a. NERVOUS SYSTEM – Brain disease; stroke, epilepsy-seizures, fainting or dizzy spells; cerebral palsy; other nervous system disorders.

☐ ☐ b. PSYCHIATRIC – Psychiatric counseling; marriage counseling; family therapy; addiction to narcotics, barbiturates, amphetamines, or other drug dependency; nervous or mental disorders; alcoholism.

☐ ☐ c. GENITOURINARY SYSTEM – Kidney, prostate, bladder, menstrual or other female disorders.

☐ ☐ d. MUSCULOSKELETAL – Arthritis; rheumatism, bodily deformity; congenital abnormality; ruptured disc; or any muscle disorders.

☐ ☐ e. CARDIOPULMONARY – High blood pressure; heart disease; circulatory disorders; disease; tuberculosis.

☐ ☐ f. DIGESTIVE SYSTEM – Mouth; ulcers; disease of stomach; gall bladder; colon or intestines; hernia; rectal disorders.

☐ ☐ g. EYE, EAR, NOSE, THROAT – Asthma; sinus; allergies; disease of nose or ears; disease of throat or tonsils; impairment of sight or hearing.

☐ ☐ h. INCAPACITATION – Physical handicaps; mental retardation; disabled or incapacitated as defined by Medicare.

☐ ☐ i. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), Kaposi Sarcoma, Pneumocystis Carinii Pneumonia, or Antibodies to Human T-Lymphotrophic Virus Type III (HTLV-III).

☐ ☐ j. Sexually transmitted diseases such as syphilis, gonorrhea, herpes, genital warts.

☐ ☐ k. Tumor or mass, cancer/liver disorders; hepatitis; thyroid disorders; blood disease; hemophilia; diabetes; skin disorders; infections or any other medical advice, examination, not disclosed above?

☐ ☐ l. Is anyone listed on this application pregnant? If yes, when is the expected due date? _____

☐ ☐ m. Has anyone listed on this application been advised to undergo a surgical operation or procedure within the next six months?

☐ ☐ n. Is anyone listed on this application currently taking prescription drugs, including injectables? If YES, please list on separate sheet and attach to this application.

If you need more room, please attach additional information to this application, write your full name on the attachment.

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

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: _____(MM/DD/YYYY)_____

☐ Part B / Effective Date: _____(MM/DD/YYYY)_____

MEDICARE HIC#: _____

Is your Spouse eligible for Medicare? ☐ YES ☐ NO

☐ Part A / Effective Date: _____(MM/DD/YYYY)_____

☐ Part B / Effective Date: _____(MM/DD/YYYY)_____

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

Section G - Disclosure Acknowledgment

You must sign both places in Section G to be considered for coverage.

I understand that I am enrolling in a health care plan issued by Alliant Health Plans, Inc. (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 the website, AlliantPlans.com. I may also verify provider status by contacting Client Services at (866) 403-2785. 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: Applicable State and/or Federal 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 consum- er 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 Client Services.

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.

Please 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 enrollment, 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 enrollment, 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)