Group Enrollment Application

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage: Please provide Hire Date: ____/____/____

☐ Change policy coverage: Please provide current policy number: A17360001

☐ Add dependent(s) to current coverage: Please provide current policy number: A17360001

☐ Term/Change dependent: Change Date: _____

Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans.

Applications must be received during the Open Enrollment period. Outside the above Open Enrollment period the applicant may still enroll if he/she has a special event as defined below. Notice of a special event must be received by Alliant Health Plans within 30 days of the special event.

Special Events

Please check the special event:

☐ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium

☐ Loss of Minimum Essential Coverage due to dissolution of marriage

☐ Marriage

☐ Adoption or placement for adoption or appointment of guardianship

☐ Birth

Please provide the date of the special event: _____

If you are applying due to a special event and your application is approved, your effective date is as follows:

- In the case of birth, adoption or placement for adoption or appointment of guardianship, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship; or
- In the case of marriage, or loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application.

NOTE: Special Events require supporting documents (i.e. Marriage Certificate/Divorce Decree, etc.) Please provide supporting documents as an attachment to this application. All possible Special Events may not be listed on this form, check with your Human Resources Department.

Section B – EMPLOYEE Information

Last Name	First Name	MI	Social Security Number*

Home Address (street and P.O. Box if applicable)			

City	State	ZIP	County

Billing Address (street and P.O. Box if different from above)		

City	State	ZIP

Marital Status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of Birth / /

Primary Phone Number ( )	Secondary Phone Number ( )	E-mail**

**This information is required by the Federal Government. (Section 111 of Public Law 110-173)*

***This information is used for communication purposes only and will not be disclosed.*

Section C – Spouse to be Covered Information

Last Name	First Name	MI [redacted] Term/Add

Social Security Number*	Sex ☐ M ☐ F	Date of Birth / /	Term ☐

**This information is required by the Federal Government. (Section 111 of Public Law 110-173)*

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your children, or your spouse's children (to the end of the calendar month in which they turn age 26). (List all dependents beginning with the eldest.)

Last Name	First Name	MI	Sex	Date of Birth mm/dd/yyyy	Social Security Number*	Relationship to Applicant	Term/Add
			☐M☐F	/ /		☐ Child ☐ Other:_____	Term ☐ Add ☐
			☐M☐F	/ /		☐ Child ☐ Other:_____	Term ☐ Add ☐
			☐M☐F	/ /		☐ Child ☐ Other:_____	Term ☐ Add ☐
			☐M☐F	/ /		☐ Child ☐ Other:_____	Term ☐ Add ☐
			☐M☐F	/ /		☐ Child ☐ Other:_____	Term ☐ Add ☐

**This information is not required*

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

If **NO**, who? _____

Are all applicants listed on this application United States citizens, nationals or lawfully present non-citizens? ☐Yes ☐No

If **NO**, who? _____

Section E – Medical Coverage

Plan Name and Deductible/Coinsurance Options

Select Plan(s)

	☑ Other: 14CY2505 (Rx19)
☐ Other:	☐ Other:

Section F – 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? ☐ Yes ☐ No

If **YES**, who and reason:

_____

Start date of benefits/coverage:_____/____/_____End date of benefits/coverage:_____/____/_____

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, simply write ALL in space below.	Identification Number(s)
Name and phone number of prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage

Will you be cancelling this coverage if approved for Alliant Health Plans coverage? ☐ Yes ☐ No

If **YES**, what is the cancellation date? _____

Section G – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully.

APPLYING FOR COVERAGE: 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: a) number, mix and location of participating/network health care providers; b) limitations of choices of participation/network health care providers; and c) disclosure of contractual relationship between participation/network provider and Alliant Health Plans. This application shall be altered solely by the applicant or with his or her written consent.

Section I: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

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:

- Employee's spouse, or children age 25 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the 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 children reach age 26.

The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The 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.

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.

In signing this application I represent that: I have read or have had read to me the completed application and I realize any false statement or misrepresentation in the application may result in loss of coverage.

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. O.C.G.A. 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; 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 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 Department at 1-800-811-4793 for details.

Sign here	Applicant signature X	Date (MM/DD/YYYY)

Please Print, Sign, then scan and submit to Helen Troha at helen.troha@ackermansecurity.com or hand deliver to HR.

Print Reset

ONLY USE THIS PAGE IF YOU ARE <u>DECLINING</u> COVERAGE

☐ **<u>DECLINING COVERAGE:</u>** 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.

Sign here	Applicant signature X	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 your 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.