GROUP ENROLLMENT APPLICATION

[Print using INK]

DATE OF EMPLOYMENT ___-___-____

EFFECTIVE DATE OF COVERAGE ___-___-____

☐ New Enrollment
☐ Add Dependent
☐ Open Enrollment

Qualifying Event
(Select from below)
☐ Marriage (License Req'd)
☐ Divorce (Decree Req'd)
☐ Birth / Adoption
☐ Loss of Coverage
Creditable Coverage Cert. Req'd
☐ Other: _____

GROUP NUMBER: A1736001

DEPT CODE:

COMPANY NAME: Ackerman Security Systems

EMPLOYEE LAST NAME | FIRST | MI

EMPLOYEE HOME ADDRESS

CITY | STATE | ZIP+ 4 CODE

HOME PHONE | BUSINESS PHONE | COUNTY: (Where you live)

EMAIL ADDRESS:

Do you wish to receive all member material by E-mail instead of hard-copy? ☐ YES ☐ NO

COVERAGE APPLIED FOR:
PPO: 10PP2505 w/ RX AP19EC

EMPLOYMENT STATUS:
☐ Active ☐ Leave of Absence
☐ Retired ☐ Disabled
☐ COBRA: Start Date: _____
Reason on COBRA: _____

COMPANY DIV/DEPT

WAIVER OF COVERAGE: Complete ONLY if Waiving Coverage

☐ **I waive medical coverage for:** ☐ Self (and Dependents) ☐ Spouse ☐ Dependents

State Reason for Waiving Coverage: _____

SIGNATURE _____ **DATE** _____

NOTE: Be sure to PRINT your full name in the top section

Complete the following on each person applying for coverage:

EMPLOYEE

LAST NAME | FIRST | MI | DATE OF BIRTH

SOCIAL SECURITY NO. | Height: | Weight:

SEX ☐ MALE ☐ FEMALE | DISABLED? ☐ YES ☐ NO

SPOUSE

LAST NAME | FIRST | MI | DATE OF BIRTH

SOCIAL SECURITY NO. | Height: | Weight:

SEX ☐ MALE ☐ FEMALE | DISABLED? ☐ YES ☐ NO

CHILD

LAST NAME | FIRST | MI | DATE OF BIRTH

SOCIAL SECURITY NO. | Height: | Weight:

SEX ☐ MALE ☐ FEMALE | Is this is a "Step-Child"? ☐ YES ☐ NO | DISABLED? ☐ YES ☐ NO

CHILD

LAST NAME	FIRST	MI	DATE OF BIRTH

SOCIAL SECURITY NO. ___-___-____ Height: Weight:

SEX ☐ MALE ☐ FEMALE | Is this is a "Step-Child"? ☐ YES ☐ NO | DISABLED? ☐ YES ☐ NO

CHILD

LAST NAME	FIRST	MI	DATE OF BIRTH

SOCIAL SECURITY NO. ___-___-____ Height: Weight:

SEX ☐ MALE ☐ FEMALE | Is this is a "Step-Child"? ☐ YES ☐ NO | DISABLED? ☐ YES ☐ NO

Medical Information

SECTION A

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	Answer by Checking YES or NO for each question
☐	☐	a. NERVOUS – 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 6 months?
☐	☐	n. Is anyone listed on this application currently taking prescription drugs, including injectibles? *If YES, please list on separate sheet and attach to this application.*

LAST NAME	FIRST	MIDDLE

If you need more room, please attach additional information to this application. Be sure to include YOUR full name in case it gets separated.

COMPLETE THIS SECTION IF ANY QUESTIONS WERE ANSWERED "YES" IN SECTION A ON PAGE 2

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 ☐☐-☐☐-☐☐☐☐

Part B / Effective Date ☐☐-☐☐-☐☐☐☐

Is your **Spouse** eligible for Medicare? ☐ YES ☐ NO

Part A / Effective Date ☐☐-☐☐-☐☐☐☐

Part B / Effective Date ☐☐-☐☐-☐☐☐☐

MEDICARE HIC#: ☐☐☐☐☐☐☐☐☐☐☐☐

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

DISCLOSURE ACKNOWLEDGEMENT: I understand that I am enrolling in a health care plan issued by Alliant Health Plans ("AHP") 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 that I receive, and I will be fully responsible for any and all costs not covered by AHP. I have reviewed the list of participating providers which can be found on AHP's web site, www.AlliantPlans.com. I may also verify provider status by contacting Customer Service at the number listed on my member ID card. I understand that 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 AHP 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 AHP 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 services 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.

YOU MUST PROVIDE YOUR SIGNATURE HERE AND ON PAGE 4 TO BE CONSIDERED FOR COVERAGE

APPLICANT or LEGAL GUARDIAN SIGNATURE _____ **DATE SIGNED** _____

PRINT NAME _____

LAST NAME	FIRST	MIDDLE

IF YOU ARE APPLYING FOR COVERAGE AND PORTABILITY RULES APPLY, PLEASE FURNISH PROOF OF YOUR PRIOR COVERAGE (Creditable Coverage Certificate) WITH THIS APPLICATION

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 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 the Customer Service Department.

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 Health Plans (hereinafter referred to as the Company). I understand and agree that 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 that membership will continue according to the terms of the contract between my Employer and the Company. I hereby authorize my Employer to periodically deduct any charge due from me hereunder and to remit same to the Company along with any contribution due from the Employer. I understand and agree that the Company reserves the right to change the subscription 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 WE 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 emtional 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 the Company, its reinsurer or its legal representatives, and its affiliates.

* The information obtained by use of this authorization may be used by Alliant Health Plans to determine eligibility I declare that all statements and information made hereon are complete and true to the best of my knowledge.
* Any information obtained will not be released by Alliant Health Plans 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 requst. 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 shown 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 Health Plans.

YOU MUST PROVIDE YOUR SIGNATURE HERE AND ON PAGE 3 TO BE CONSIDERED FOR COVERAGE

APPLICANT or LEGAL GUARDIAN SIGNATURE _____ **DATE SIGNED**_____

PRINT NAME _____

LAST NAME	FIRST	MIDDLE

Please print, sign, then scan and submit an electric copy or hand deliver to HR.

Reset | Print & Submit