Health Alliance INDIVIDUAL PLANS℠
301 S. Vine St., Urbana, IL 61801

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a health plan only from November 1 to January 31. There are exceptions that may allow you to enroll in a health plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for a special enrollment period. If we later determine that this information is incorrect, you may be disenrolled. The "Date of Event" is the date of the event (marriage, divorce, birth of a child, loss of coverage, etc.) that may qualify you for special enrollment.

- ❒ If you and/or your Dependents involuntarily lose coverage due to loss of eligibility, which may include loss of coverage resulting from termination of employment, a reduction in the number of work hours, a reduction in or termination of employer contributions, or a significant increase in the cost of your plan or you receive a notice of the loss of minimum essential coverage, you and your eligible Dependents may enroll in the Plan. The "Date of Event" is the last full day of coverage with previous carrier.
  Date of Event: _____
- ❒ If you acquire a new Dependent through marriage or a civil union partnership you may enroll yourself and/or your new Legal Spouse and eligible Dependents in the Plan.
  Date of Event: _____
- ❒ If you acquire a new Dependent through birth, adoption or placement of a child pending legal adoption, you may enroll yourself, your eligible Legal Spouse, the newborn or newly adopted child and any other eligible Dependent children not currently enrolled in the Plan.
  Date of Event: _____
- ❒ If you gain a new Dependent under court order. You may enroll yourself, your Legal Spouse, the new Dependent or any other eligible Dependent not currently enrolled in the Plan.
  Date of Event: _____
- ❒ If you or your eligible Dependents enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation or inaction of an officer, employee or agent of the Health Insurance Marketplace for Health and Human Services (HHS), or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or inaction. If you or your eligible Dependent's enrollment in a health plan is unintentional, inadvertent, or erroneous resulting from action by a non-Exchange entity.
  Date of Event: _____
- ❒ If you or your eligible Dependents adequately demonstrates to the health insurance marketplace that a qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relations to the enrollee.
  Date of Event: _____
- ❒ If you or a qualified individual becomes newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost sharing reductions.
  Date of Event: _____
- ❒ If a qualified individual or enrollee, or his or her Dependent gains access to new qualified health plans as a result of a permanent move.
  Date of Event: _____
- ❒ If you experience a loss of a Dependent or Dependent status through divorce or legal separation or death. If an enrollee or a Dependent dies, the Exchange must ensure coverage is effective on the first day of the month following the plan selection, or it may permit the enrollee or his or her Dependent(s) to elect regular effective dates.
  Date of Event: _____
- ❒ If a qualified individual or his or her Dependent was not previously a citizen, national or lawfully present and gains such status.
  Date of Event: _____

_____ _____

Sign Date

❒ I agree that the typed name above shall be treated as a valid signature for all purposes of this form.

Illinois Application for Individual & Family Health Insurance Coverage

Health Alliance INDIVIDUAL PLANS℠

For assistance in completing this application, please contact your agent, visit HealthAlliance.org or call 1-877-686-1168 Monday through Friday, 8 a.m.–5 p.m. Mail your completed form to Health Alliance Medical Plans, ATTN: Individual Services Enrollment, 301 S. Vine St., Urbana, IL 61801. You may also email your completed application to individualenrollment@healthalliance.org or fax it to 217-337-3425.

INSTRUCTIONS:

1. Any information you provide in this application is confidential.
2. The answers you provide in this application must be true and complete, to the best of your knowledge and belief. Do not leave any question unmarked.
3. An intentional misrepresentation may result in your policy being modified or terminated, or in claims being reduced or denied.
4. You should have the following information available for each person requesting coverage:
   - Social Security Number and date of birth
   - Information about any current or prior insurance coverage in effect within the last 12 months
   - Personal health information
5. For purposes of this application, the term "dependent" refers to any child up to age 26 (or age 30 for military veterans) for whom you are requesting coverage, regardless of whether the child may be considered a dependent for tax or other purposes.

Primary Applicant Information		
Name (Last)	(First)	(MI)
Residential Street Address:		Apt. #:
City:	State:	Zip:
Mailing Address (if different):		Apt. #:
City:	State:	Zip:
Primary Phone Number: ( )	Secondary Phone Number: ( )	
Email Address:		
Please check one of the following boxes: ❑ New Application ❑ Dependent Addition ❑ Plan Change ❑ SEP (Outside the open enrollment period, you must have a Qualifying Event to apply for coverage and submit the Special Election Period form with your application.)		
Requested Effective Date: _____ (Coverage not in force until Health Alliance approves your application and determines the effective date.)		
In the last 6 months, has the policyholder or any dependent(s) used any tobacco product at least 4 times a week (such as cigarettes, snuff, chewing tobacco, or any nicotine substitution product)? ❑ Yes ❑ No If yes, indicate who: ❑ Primary Applicant ❑ Spouse/Civil Union Spouse ❑ Dependent Children		
Primary Care Physician (PCP):		
Date of Birth: / /	Social Security Number:	Gender: ❑ Male ❑ Female

Would you like to receive your member materials electronically? ❑ Yes ❑ No If yes, please authorize below.

I authorize Health Alliance to provide the plan documents and materials to me through HealthAlliance.org. I acknowledge that I have access to resources that allow me to access my Health Alliance account and have a current email address on file with Health Alliance. I understand I will be notified when documents become available or updated on my Health Alliance account. I understand I may request a paper copy at any time and/or I may revoke electronic distribution of materials at any time by contacting Health Alliance.

Electronic Distribution Authorization Signature _____

Date: _____

Dependent Information

List all family members you wish to include under the policy. For more information regarding the available coverage, please check with Health Alliance.

Note: For purposes of this application, an "eligible military veteran" is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, and who received a release or discharge other than a dishonorable discharge.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Spouse/Civil Union Spouse Name (Last) (First) (MI)	
Social Security Number (for internal use only):	Date of Birth (mm/dd/yyyy):
Gender: ☐ Male ☐ Female	
Primary Care Physician (PCP):	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth (mm/dd/yyyy):
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Primary Care Physician (PCP):	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth (mm/dd/yyyy):
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Primary Care Physician (PCP):	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth (mm/dd/yyyy):
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Primary Care Physician (PCP):	
Dependent Name (Last) (First) (MI)	
Relationship to Applicant:	Date of Birth (mm/dd/yyyy):
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Primary Care Physician (PCP):	

Plan Options: Please choose one.

☐ HMO 1500a Gold	☐ POS 2000 Gold
☐ HMO 1500b Gold	☐ POS 6000b Silver
☐ HMO 3000b Silver	☐ POS HSA 2100a Gold*
☐ HMO 4000b Silver	☐ POS 3750c Bronze
☐ HMO 4500 Silver	☐ POS 5000a Bronze
☐ HMO 5000c Silver	☐ POS HSA 6000 Bronze
☐ HMO 6850	☐ PPO 3250a Gold
☐ HMO 3500 Bronze	☐ PPO 4500b Silver
☐ HMO 4000d Bronze	☐ PPO 4500 Bronze

Additional Coverage

Vision:	Dental:	
☐ VSP Vision Choice Plan $20 exam copay	☐ Delta Dental PPO Bronze Plan	
	☐ Delta Dental PPO Silver Plan	☐ add Kids Basic Plan
	☐ Delta Dental PPO Gold Plan	☐ add Kids Basic Plan
	☐ Delta Dental PPO Kids Basic Plan	

*This plan includes an aggregate deductible. If one person is on the plan, he or she works toward the single deductible. If more than one person is on the plan, they work toward the family deductible. Under an aggregate deductible, sometimes it may be better, if there are only two people in your family, for each to apply for their own coverage.

Current/Prior Coverage Information

For EACH person listed on this application, please indicate any public health insurance coverage (for example, Medicare, HFS Medical Card, All Kids, Family Care, or other federal and state programs like the VA) or private health insurance in effect within the **last 12 months**. Each person applying for insurance must be listed below. If health insurance coverage was not in effect within the **last 12 months**, please indicate **NONE**.

Self Name (Last) (First) (MI)

Current/Most Recent Coverage: ☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer ____________________________)
☐ VA (Facility ____________________________)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________
Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Prior Coverage (if any): ☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer ____________________________)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________

Spouse/Civil Union Spouse Name (Last) (First) (MI)

Current/Most Recent Coverage: ☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer ____________________________)
☐ VA (Facility ____________________________)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________
Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Prior Coverage (if any): ☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer ____________________________)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________

Dependent Name (Last) (First) (MI)

Current/Most Recent Coverage: ☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer ____________________________)
☐ VA (Facility ____________________________)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________
Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Prior Coverage (if any): ☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer ____________________________)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________

Dependent Name (Last) (First) (MI)

Current/Most Recent Coverage: ☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer ____________________________)
☐ VA (Facility ____________________________)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________
Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Prior Coverage (if any): ☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer ____________________________)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________

Dependent Name (Last) (First) (MI)

Current/Most Recent Coverage: ☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer ____________________________)
☐ VA (Facility ____________________________)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________
Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Prior Coverage (if any): ☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer ____________________________)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________

Dependent Name (Last) (First) (MI)

Current/Most Recent Coverage: ☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer ____________________________)
☐ VA (Facility ____________________________)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________
Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

Prior Coverage (if any): ☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer ____________________________)
Dates of Coverage: From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy): ____________________

* If answering "Yes" please carefully read the following notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT & HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Health Alliance. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
3. It is recommended that you do not terminate your present contract until you are certain that your application for the new contract has been approved by Health Alliance.

Acknowledgement & Signature

Signature – Adult applicants must sign this form below. Parent or guardian signature is required for applicants under the age of 18. By signing this form, you certify the following:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are, to the best of my knowledge and belief, true and complete.
- Neither Health Alliance nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the insurance carrier's other rights and requirements.
- I understand that if I intentionally omit or provide false information on or in relation to this application, this policy may be cancelled retroactively, in which case any claim I submit may not be paid by Health Alliance. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud.

I understand that the information I have provided in this application will be used by Health Alliance and its affiliates to make decisions regarding eligibility, enrollment and premium risk rating.

I understand that the medical information provided also includes my spouse/civil union spouse and/or dependents' information.

I understand that I may be asked for authorization to disclose my medical, claim or benefit records at a later time.

I understand that I should retain a duplicate copy of this application for my own records.

I understand that no coverage shall be in force until approved by Health Alliance. If approved, coverage will be in force as of the effective date determined by Health Alliance.

I understand that this application will become part of the contract between Health Alliance and me.

I understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws.

I understand I may revoke this authorization at any time by giving advance written notice Health Alliance. Revocation of this authorization form will not affect actions Health Alliance took in reliance on this form prior to the written notice of revocation.

A photographic copy of this acknowledgment shall be as valid as the original.

I authorize the insurance carrier to electronically transmit the information contained herein.

I agree this Authorization shall be valid for two and one-half (2 ½) years from the latest signature date below.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

I HAVE READ AND CONSIDERED THE CONTENTS OF THIS FORM. BY SIGNING THIS FORM, I HEREBY AUTHORIZE THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ Date _____
Primary Applicant (or Authorized Legal Representative) Signature

_____ Date _____
Spouse/Civil Union Spouse Signature (ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

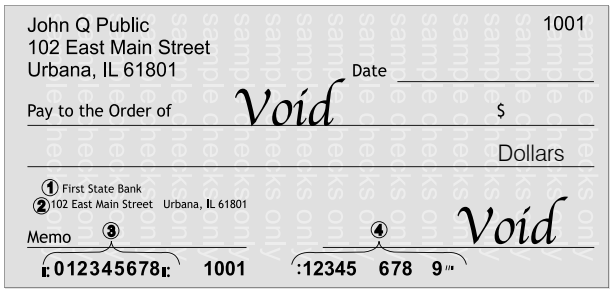
_____ Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

Automatic Premium Payment Program

Sign up for automatic payments and enjoy knowing your payment is on time. It's the easy way to pay. Your payment will happen on the first day of each month or on the closest business day. If the amount is going to change, we'll let you know at least 30 days before it does.

If you have any questions, please call our Customer Service Department at 1-866-247-3296, Monday through Friday, 8 a.m. to 5 p.m.

To get started, choose one of the options below and fill out the form.
Option A – Pay from your checking or savings account.
Option B – Pay with your credit card.



Sample voided check
1. Name of financial institution, **2**. Branch, City, State, ZIP, **3**. ABA routing number, **4**. Account number

Option A – Automatic Premium Payment Authorization (please print)

Name (First, Middle Initial, Last)

Social Security Number

___ ___

Phone Number ( )

Make this deduction from:

☐ **Checking** (Enclose voided check) ☐ **Savings**

See voided check sample for this information.

Financial Institution of Payor

Name _____

Branch _____

City _____ **State** _____ **ZIP** _____

ABA# _____

Account# _____

I hereby authorize Health Alliance Medical Plans, Inc., and the financial institution named above to initiate monthly debit entries on the appropriate date and in the amount of the current premium for my plan and to initiate, if necessary, credit entries and adjustments for any debit entries in error to the account and financial institution indicated above. This authority is to remain in effect until Health Alliance has received written notification from me of its termination in such time as to afford Health Alliance and the financial institution a reasonable opportunity to act on it.

Signature _____ Date _____

Option B – Authorization for Monthly Recurring Credit Card Transactions to Pay Premium (please print)

I hereby authorize Health Alliance to keep my signature on file and to process a monthly recurring credit card transaction for payment of my health insurance premium, which is processed on the 1st of every month. I understand this will begin with my next payment.

I acknowledge that this recurring payment will continue until the expiration date of the credit card listed below or until I notify Health Alliance in writing to discontinue the recurring payment.

Member Name: _____

Member Number (if known): _____

Cardholder Name: _____

Card Type: ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number: _____

Expiration Month/Year: _____

Cardholder Billing Address: _____

City, State, ZIP: _____

Three-digit security code located on the back of the card in the signature strip: _____

Cardholder Signature: _____

Date: _____

TO BE COMPLETED BY AGENT
Agent/Producer Information

I certify that:
- All answers provided in this application were completed by or provided by the applicant.
- I have reviewed this enrollment form to ensure that all required items have been completed.
- I am not aware of any information not disclosed on this enrollment form relating to the health, habits or reputation of any person listed on this enrollment form, which might have a bearing on the risk.

Agent/Broker

Agent Name:	ID#/Code:
Agency:	Phone: ( )
Email:	

Producer Signature: _____

Date Signed: _____
(A faxed signature shall be valid as an original signature.)