



ENROLLMENT FORM

Please print clearly. (Blue or black ink only.)

DATE OF EMPLOYMENT		
EMPLOYMENT STATUS:		
<input type="checkbox"/> Active	<input type="checkbox"/> Leave of Absence	<input type="checkbox"/> Retired
<input type="checkbox"/> Disabled	<input type="checkbox"/> Cobra	

Complete the following information on you and your family.

GROUP NUMBER A	DIVISION	DIVISION NAME
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EMPLOYEE HOME ADDRESS

CITY	STATE	ZIP+ 4 CODE
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HOME PHONE	BUSINESS PHONE	EMAIL ADDRESS
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EMPLOYEE	LAST NAME	FIRST	MI	DATE OF BIRTH
	SOCIAL SECURITY NO.			
	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		

SPOUSE	LAST NAME	FIRST	MI	DATE OF BIRTH
	SOCIAL SECURITY NO.			
	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		

CHILD	LAST NAME	FIRST	MI	DATE OF BIRTH
	SOCIAL SECURITY NO.			
	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	COLLEGE STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO (REQUIRES PROOF OF ENROLLMENT)		DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO

CHILD	LAST NAME	FIRST	MI	DATE OF BIRTH
	SOCIAL SECURITY NO.			
	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	COLLEGE STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO (REQUIRES PROOF OF ENROLLMENT)		DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO

CHILD	LAST NAME	FIRST	MI	DATE OF BIRTH
	SOCIAL SECURITY NO.			
	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	COLLEGE STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO (REQUIRES PROOF OF ENROLLMENT)		DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO

Complete if waiving other coverage or Medicare:

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

State Reason for Waiving Coverage: _____

Complete if you have other coverage

After coverage begins, will you or any dependents have any other medical insurance, including Medicare? (check one) YES NO

Insurance _____
 Co. Name: _____
 Policy No: _____
 Insurance _____
 Co. Address: _____

Insurance _____
 Effective Date: _____
 Policyholder Name: _____

Policyholder Date of Birth: _____

Who is covered? Self Spouse Family

Are you eligible for Medicare? YES NO

Is your spouse eligible for Medicare?

Part A / Effective Date _____

YES NO

Part A / Effective Date _____

Part B / Effective Date _____

Part B / Effective Date _____

MEDICARE HIC # _____

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

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

Read, Sign and Date Below:

IF YOU ARE APPLYING FOR COVERAGE AND PORTABILITY RULES APPLY, PLEASE FURNISH PROOF OF YOUR PRIOR COVERAGE WITH THIS APPLICATION.

I declare that all statements and information made hereon are complete and true to the best of my knowledge. I understand that any fraudulent misstatements or omissions may void all coverage applied for on any member on this application on a retroactive basis for up to two (2) years from the contract effective date.

I hereby acknowledge that Alliant Health Plans (as applicable) 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 on choices of participating/network health care providers; and
- c. disclosure of contractual relationship between participating/network provider and Alliant Health Plans.

APPLICANT'S SIGNATURE _____ **DATE SIGNED** _____
PRINT NAME _____

RIGHTS AND OBLIGATIONS

I hereby apply for myself and/or my eligible family members for (a) 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 Group Application and the Master Group Contract 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 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. _____(initial)

I hereby authorize any hospital, physician, psychiatrist, psychologist, counselor, psychiatric hospital or other provider, dispenser of prescription drugs, appliances, ambulance service or any person or any institution rendering services to me or members of my family if covered hereunder, to furnish to the Company all requested information concerning treatment, advice, psychiatric care or medical care for previous or future conditions, illnesses or disabilities. _____(initial)

I declare that all statements made herein including the information provided on the front of this application are complete and true to the best of my knowledge and belief, and agree that the Company may cancel this coverage within two (2) years from the effective date, for any ineligible family member or one on whom erroneous or false information has been submitted, personally assuming liability for reimbursement to the Company for any benefit payment made on behalf of such family member. After this contract has been in force for a period of two (2) years during the lifetime of the insured, it shall become incontestable as to the statements in the application. I understand that I am responsible for giving notice to my Employer of any changes in my status and that of family members which may affect coverage. _____(initial)

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.

LAST NAME	FIRST	MIDDLE
<input type="text"/>	<input type="text"/>	<input type="text"/>

LAST NAME										FIRST										MIDDLE	
<input type="checkbox"/>																					

Tobacco Use and Wellness Participation

Check one box and initial where indicated:

I and/or my covered dependent(s) currently use tobacco products

I and/or my covered dependent(s) currently do not use tobacco products

I understand that by not using tobacco products, my employer will reward me by paying a higher portion of my health premiums. I also understand that any misrepresentation of tobacco use by me is grounds for disciplinary action up to and including termination and/or loss of my medical coverage. If I begin to use tobacco products, I agree to notify a health plan representative within three days and understand that the portion of my premium which I am responsible for paying will increase. I understand and agree that my premium payment can be changed once per calendar year based on tobacco use.

Further, I understand that if I currently do use tobacco products, I may also be eligible for this reward if I complete an approved nicotine cessation program. I understand that if I am interested in attending such a program, I should contact my Human Resources office for further details.

I also understand that by completing the wellness program, my employer will reward me by paying a higher portion of my health premiums and that if I choose not to complete the program, the portion of the premium which I am responsible for paying will increase.

Initials: _____

For Active Employees:

Is your spouse eligible for medical coverage from his/her employer (circle one):

Yes No My spouse is not employed

For Retirees:

Are you eligible for medical coverage from your current employer (circle one):

Yes No I am not currently employed

Is your spouse eligible for medical coverage from his/her employer (circle one):

Yes No My spouse is not currently employed

I agree to the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true and agree that they will be the basis of the issuance of any coverage by any underwriter or carrier. I also understand that any false or misleading statements on this form may be grounds for termination and/or refusal to pay claims based on the information provided.

I also agree to notify a City of Dalton Health Plan representative within 10 working days should my spouse become eligible for coverage from his/her employer and/or if I become eligible from my employer.

PARTICIPANT SIGNATURE

DATE SIGNED