Alliance Health and Life Insurance Company Enrollment Application

Alliance Health and Life Insurance Company

To be filled out by employer:			
Group ID:	Sub-Group ID:	Class ID:	Effective Date of Coverage:

Important: List family members you are covering. Legal first name and middle initial only. Last name if different from yours.

Note: Orange shaded areas are required.

To be filled out by applicant:

Enrolling for: ❑ EPO ❑ PPO Plan Option _____ ❑ Cigna

Last Name: Legal First Name: Middle Initial: Primary Phone: Birth Date: Male ❑ Female ❑ Tobacco Use (over last six months)** ❑ Yes ❑ No Social Security Number:

Address: Apt.: City: State: Zip: County: Email:

Name of Employer:	Date of Hire (required):	Location Code:	Date of Retirement (If Applicable):

Name and Middle Initial of Dependents:	Social Security Number:	Birth Date:*	Sex:	Tobacco Use (over last six months):**	Relationship (See Codes Below):
				❑ Yes ❑ No	
				❑ Yes ❑ No	
				❑ Yes ❑ No	
				❑ Yes ❑ No	
				❑ Yes ❑ No	

*A permanently disabled child of the Applicant (or Applicant's Spouse) can be enrolled even if over the age of 26. However, the permanently disabled child over the age of 26 cannot be married, must have been permanently disabled before reaching the age of 26 and must rely upon the Applicant (or Applicant's Spouse) for more than half of their support. We require proof of permanent disability within 31 days of enrollment.

**Applies to any applicant over age 18 who uses tobacco products regularly (four or more times per week), excluding those for religious use.

Relationship Codes:

M–Subscriber	H–Husband/Spouse	D–Daughter (Dependent)	OP–Other Partner (University Clients Only)	SD–Sponsored Dependent (without Medicare)
W–Wife/Spouse	S–Son (Dependent)	DP–(Domestic Partner)	HD–Permanently Disabled (Dependent)	SR–Senior Rider (with Medicare)

Does anyone listed above have other health care coverage? If yes, complete the following:

❑ Self ❑ Spouse ❑ Dependent

Type of coverage ❑ BCBS ❑ Other _____

Medicare Number _____

Effective Date for Part A _____

Effective Date for Part B _____

Medicaid Number _____

Have you or any of your dependents previously been a HAP or Alliance member? ❑ Yes ❑ No

Name _____

Former Number _____

Name/# _____

Name/# _____

Name/# _____

Are you to provide medical coverage for a child(ren) listed above according to a qualified medical child support order (QMSCO)? ❑ Yes ❑ No

If yes, please attach document.

Does a qualified medical child support order (QMSCO) exist for any dependent child(ren) listed on this application? ❑ Yes ❑ No

If yes, please attach document.

MUST be signed below by person applying for coverage.

I am applying for the group health benefits that I am eligible for with my employer. All of the information I have given in this application is true and complete.

I know that if I give any false or misleading information on purpose my enrollment may be rejected or my enrollment may be terminated back to the date of the application. I know that if I leave out important information on this form my enrollment may be rejected or my enrollment may be terminated back to the date of the application. I know that I must also give true and complete information for my dependents (such as children, spouse or partner) or their enrollment may be rejected or terminated back to the date of the application.

Applicant Signature

Date: MM/DD/YY

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