

APPLICATION

ALABAMA HEALTH INSURANCE PLAN

SEND APPLICATION AND CERTIFICATE OF CREDITABLE COVERAGE TO:
 ALABAMA HEALTH INSURANCE PLAN ADMINISTRATOR
 POST OFFICE BOX 304900
 MONTGOMERY, ALABAMA 36130-4900
 TELEPHONE: 1.866.833.3375 or 334.263.8311 / FAX: 334.263.8511

APPLICANT INFORMATION (Please print)

Name (Last, First, Middle Initial)		Sex	<u>Check which coverage plan elected.</u>	
Social Security Number	Age	Date of Birth	<input type="checkbox"/> \$4,000 Deductible BlueCross/Blue Shield Traditional Indemnity	
Address of Residence			<input type="checkbox"/> \$2,500 Deductible Blue Cross/Blue Shield Traditional Indemnity	
P O Box (if applicable)			<input type="checkbox"/> \$1,000 Deductible Blue Cross/Blue Shield Traditional Indemnity	
City	State	Zip Code	<input type="checkbox"/> United Healthcare, Inc. Managed Care Plan	
E-mail Address			Coverage selected: Individual <input type="checkbox"/> Individual & Children <input type="checkbox"/>	
Home Telephone Number	Cell Telephone Number		Coverage Effective Date Requested _____/_____/_____	
()	()		Do you use tobacco products? _____ yes _____ no	
Driver's License Number (Attach copy of DL)	State Issued		Have you applied for Medicare? _____ yes _____ no	
Current Employer	Employer's Telephone #		Are you eligible for Medicare? _____ yes _____ no	
Previous Employer	Previous Employer's Telephone		Have you applied for Medicaid? _____ yes _____ no	
Name of Last Group Insurance	Group Number		Are you eligible for Medicaid? _____ yes _____ no	
Applicant's Contract Number	Date Coverage Ended		Were you eligible for COBRA? _____ yes _____ no	
Spouse's Name (Last, First, Middle Initial)	Date Coverage Ended		Did you exhaust your COBRA coverage? _____ yes _____ no	
			Are you married? _____ yes _____ no	
			Is health insurance offered through your employer? _____ yes _____ no	
			Is health insurance offered through spouse's employer? _____ yes _____ no	
			Spouse's employer's name _____ Employer's telephone # _____	
			() _____	

List below name, sex, and date of birth for all children to be covered. Dependent children are covered only until age 19. Dependent children over the age of 19 who are unmarried college students are eligible to age 23 with proof of full-time student status. Your spouse must submit a separate application to enroll. **Documentation is required - Birth certificate, court decree, etc.**

Last Name	First Name	Initial	Relationship to Applicant	Birth date	Social Security Number

I hereby affirm that I have completely read and fully understand the terms and conditions on the front and back of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such investigation. I understand that I must be and continue to be an Alabama resident to be eligible for the AHIP. I also agree to immediately notify the AHIP should my address change. I hereby give permission to release any information to evaluate, administer and process claims for benefits to any person, entity or representative acting on behalf of the AHIP.

Signature of Applicant

Date Signed

Note: Written proof of prior group health insurance is needed to determine eligibility. This documentation can be in the form of a Certificate of Creditable Coverage. If you are unable to provide this certificate, please contact our office for suggestions on other acceptable documentation.

CONDITIONS OF ENROLLMENT

I apply for enrollment with the Alabama Health Insurance Plan Administrator (the Plan) for me and my children listed. I wish to be enrolled under one of your health contracts with such terms and conditions as you now issue. This application (if accepted) and the Contract (as amended) will be the entire agreement between the Plan and me. The agreement can only be changed by my submission of another application that the Plan accepts, or by the Plan's amendment, rider or other written change to the health contract signed by one of its officers. By giving 30 days' written notice, the Plan may change the premiums or any provisions of the Contract. If I pay any premium after notice of the change in the premiums or the Contract, I accept the new premiums or changes in the Contract. I assume the risk of failure by the Plan to pass such notice to me.

I understand and agree that all statements and answers on this application are complete and true and that all rights to service are void if found false or incomplete. Discovery of any material information omitted by or for any person listed on this application will result in the rescission of this contract retroactively. I also understand and agree that coverage does not begin until application is accepted by the Plan in writing and an effective date of coverage is assigned.

If my application is not accepted for any reason, I understand I will receive a letter of rejection. If approved, I will be issued a billing outlining payment due dates and understand I must pay according to the effective/due date. If the application is accepted but is not paid, the policy will be canceled as null and void.



I hereby authorize any physician, health care practitioner, hospital, clinic or other medical or medically related facility to furnish the Plan, and the Plan to release to third parties, any and all records pertaining to medical history, services rendered, or treatment given to anyone making application, enrolled hereunder, or added hereafter for purposes of review, investigation, or evaluation of an application or claim. This authorization shall become effective immediately and shall remain in effect as long as necessary to enable the Plan to process the application and claims. I understand if the release of medical information requires a charge, I shall be liable, not the Alabama Health Insurance Plan.



1. I have read and personally completed all of the requested information on this form. (If not, I have attached a letter of explanation.)
2. I understand that my application requires normal processing time and may require additional time if additional correspondence is necessary.
3. I understand that if my application is accepted, my premium payments are due in advance of the month in which they are due and must be paid by the last day of that month or the contract will be canceled.
4. I hereby acknowledge and agree that all claims, disputes, and controversies of every kind and nature between me and the Plan arising out of or in connection with the Contract will be resolved by arbitration in accordance with the procedure set forth in the Contract. I hereby agree to be bound by the arbitration provisions set forth in the Contract.