

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: 1.877.619.2447 or 334.833.5945 / FAX: 334.240.3059

APPLICANT INFORMATION (Please print or type)

CHECK WHICH COVERAGE PLAN ELECTED

Name (Last, First, Middle Initial)			Sex		<input type="checkbox"/> \$2,500 Deductible Blue Cross/Blue Shield Traditional Indemnity <input type="checkbox"/> \$1,000 Deductible Blue Cross/Blue Shield Traditional Indemnity <input type="checkbox"/> United Healthcare, Inc. Managed Care Plan Coverage selected: Individual <input type="checkbox"/> Individual and children <input type="checkbox"/> Coverage Effective Date Requested ____/____/____ Do you use tobacco products? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you applied for Medicare? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you eligible for Medicare? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you applied for Medicaid? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you eligible for Medicaid? Yes <input type="checkbox"/> No <input type="checkbox"/> Were you eligible for COBRA? Yes <input type="checkbox"/> No <input type="checkbox"/> Did you exhaust your COBRA coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you married? Yes <input type="checkbox"/> No <input type="checkbox"/> Is health insurance offered through spouse's employer? Yes <input type="checkbox"/> No <input type="checkbox"/>
Social Security Number		Age	Date of Birth		
Street Address					
City		State	Zip Code		
Home Telephone Number ()		County of Residence			
Driver's License Number		State Issued			
Current Employer		Current Employer's Telephone ()			
Previous Employer's Name		Previous Employer's Telephone ()			
Name of Last Group Insurance		Group Number			
Applicant's Contract Number		Date Coverage Ended			

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.

Last Name	First Name	Initial	Documentation is required. (Birth certificate, court decree, etc.) Relationship to Applicant	Birth date	Social Security Number
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		

RELEASE

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 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 Alabama Health Insurance Plan.

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.