Physicians' Alliance Health Plan Trust

Participant Enrollment/Change Form

Requested Effective Date of Coverage Change: / /

Step 1 Employer Information

Group Name/Policy # ____________________

Date of Hire ____________________

Position Title ____________________

Hours Worked per Week ____________________

Annual Income ____________________

Reason for Application:

- ○ New Group Plan
- ○ Life Event/Date ________
- ○ Status Change ________
- ○ Dependent Add/Delete
- ○ Change Name/Address
- ○ Waiving Coverage
- ○ Termination
- ○ New Hire
- ○ Annual Open Enrollment
- ○ Late Enrollee
- ○ Change in Coverage
- ○ Other ________

Employee Type:

- ○ Active
- ○ COBRA
- ○ State Continuation
  - Start Date: / /
  - End Date: / /
- ○ Other ________
- ○ Hourly
- ○ Salary
- ○ Union
- ○ Non-Union
- ○ Retired

Step 2 Employee Information

Name ____________________
Last *First* *MI*

Social Security # ____________________

Address ____________________

Cell # ____________________

City, State, Zip Code ____________________

Work # ____________________

Email ____________________

Sex ○ M ○ F Height ________ Weight ________

Birth date ________ *mm/dd/yyyy*

Used tobacco in the last 12 months? ○ Y ○ N

Preferred Language ________ *If not English*

Physician ____________________
First & Last Name *Phone #*

Primary Care Dentist ____________________
First & Last Name *Phone #*

Marital Status *Check correct status* ○ Single ○ Married ○ Divorced ○ Widowed

Step 3 Family Information

List all enrolling (attach sheet if necessary).

Last Name *First Name* *MI* *Birth date (mm/dd/yyyy)* *Relationship* Tobacco user? ○ Y ○ N Sex ○ M ○ F

Social Security Number *Height* *Weight* *Physician Name* *Primary Dentist Name*

Last Name *First Name* *MI* *Birth date (mm/dd/yyyy)* *Relationship* Tobacco user? ○ Y ○ N Sex ○ M ○ F

Social Security Number *Height* *Weight* *Physician Name* *Primary Dentist Name*

Last Name *First Name* *MI* *Birth date (mm/dd/yyyy)* *Relationship* Tobacco user? ○ Y ○ N Sex ○ M ○ F

Social Security Number *Height* *Weight* *Physician Name* *Primary Dentist Name*

Last Name *First Name* *MI* *Birth date (mm/dd/yyyy)* *Relationship* Tobacco user? ○ Y ○ N Sex ○ M ○ F

Social Security Number *Height* *Weight* *Physician Name* *Primary Dentist Name*

Waiver of Dependent Coverage (if none listed above), for dependents eligible under this plan: I realize that I can include my dependent(s) for consideration within my proposed coverage at this time but have chosen to exclude them. I understand that hereafter I may apply for dependent coverage only during an open enrollment period for my Plan or if a qualifying event occurs as defined in the Plan's Summary Plan Description.

Step 4 Coverage Options and Selection

Medical Plan Options

Check with your employer for list of plans available.

		Plan Design Details		
• **Plan N**	Network Only Plan	**90%**	**$1,700/$3,400 Ded**	**$30/$60 OV**
• **Plan U**	Network Only Plan	**90%**	**$3,500/$7,000 Ded**	**$30/$60 OV**
• **Plan O**	Network Only Plan	**80%**	**$2,000/$4,000 Ded**	**$50/$75 OV**
• **Plan R**	Network Only Plan	**70%**	**$6,000/$12,000 Ded**	**Ded/Co-Ins OV**
• **Plan L**	PPO Plan	**85%/70%**	**$1,000/$2,000 Ded**	**$20$50 OV**
• **Plan M**	PPO Plan	**85%/70%**	**$1,000/$2,000 Ded**	**$40/$60 OV**
• **Plan P**	PPO Plan	**80%/50%**	**$5,000/$10,000 Ded**	**$50/$50 OV**
• **Plan Q**	PPO Plan	**70%/50%**	**$5,000/$10,000 Ded**	**Ded/Co-Ins OV**
• **Plan HSAS**	Low Medical Plan	**80%/60%**	**$1,700/$3,400 Ded**	
• **Plan HSAT**	Low Medical Plan	**85%/70%**	**$1,300/$2,600 Ded**	

Step 5 Product Selection

Please indicate which plan you select for you and/or your dependent(s) below. Employee and any covered dependents must participate on the same medical plan.

	Medical *select from above*	Dental/Vision *if offered*	Other	Other
Employee Only	Plan _____	○ Y ○ N	N/A	N/A
EE & Spouse/Domestic Partner	Plan _____	○ Y ○ N	N/A	N/A
EE & Dependent(s)	Plan _____	○ Y ○ N	N/A	N/A
EE & Family	Plan _____	○ Y ○ N	N/A	N/A

Step 6 Prior/Other Medical Insurance Information

This section must be completed to receive credit for prior medical coverage.

Within the last 12 months have you, your spouse, or your dependent(s) had any other medical coverage? ○ Y ○ N

If yes, please provide the following information:

Prior medical carrier name _____ Effective Date _____ End Date _____

Prior coverage type (check one of the following): ○ Employee ○ Spouse/Domestic Partner ○ Child(ren) ○ Family

On the day this coverage begins will you, your spouse, or any of your dependents be covered under any other medical health plan or policy, including another plan from this provider or Medicare? ○ Y ○ N

If yes, attach sheet with name of other carrier, names and birth dates of all individuals covered by other plan including the effective date (mm/dd/yyyy) and end date (mm/dd/yyyy).

Step 7 Waiver of Coverage

I understand that by waiving coverage at this time I will not be allowed to participate unless I qualify at a special enrollment period, the next open enrollment period, or any time upon a qualifying event as defined in the Plan's Summary Plan Description.

I decline all coverage for (check all that apply): ○ Myself ○ Spouse/Domestic Partner ○ Dependent(s)

Declining coverage due to existence of other coverage (check all that apply):

○ Spouse/s Employer's Plan
○ I (we) currently have no other coverage
○ COBRA from Prior Employment
○ Other _____
○ Covered by Medicare
○ Individual Plan
○ Tri-Care
○ Covered by Medicare
○ Medicaid
○ VA Eligibility

Applicant Print: _____ Applicant Signature: _____ Date: / /

Step 8 Termination of Coverage

This section must be completed to receive credit for prior medical coverage.

I understand that by terminating coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period, the next enrollment period, or anytime upon a qualifying event as defined in the Plan's Summary Plan Description.

Step 9 Statement of Contingent Liability

The Plan is a self-insured plan, and benefits are not guaranteed by a licensed insurer. The Plan is not covered by the Georgia Life and Health Guarantee Association. This is a fully assessable benefit plan. In the event that the multiple employer self-insured health plan is unable to pay its obligations, participating employers shall be required to contribute on a joint and several basis the funds necessary to meet any unpaid obligations. Certain other major protections offered to Georgia residents under the Georgia Insurance Code and Rules and Regulations, such as conversion rights and certain mandated or required benefits, may not be available through multiple employer self-insured plan.

Applicant Print: _____ Applicant Signature: _____ Date: / /

Step 10 Signature

I understand that I am completing a joint application for coverage and requesting indicated group coverage for myself, and if the plan provides and I (we) have chosen, for my dependent(s). I authorize any required premium contributions to be deducted from earnings or payment for services rendered and owed to me which are considered the employees contribution. Otherwise, failure to remit payment will result in the termination of coverage as outlined in the plan documents. I understand that the Plan or any affiliated organizations are not bound by any statements I have made to any agent, or to any other persons, if those statements are not written or printed on this application and any attachments. I have been informed about : 1) the number, mix and distribution of network providers associated with the plan 2) existence of limitations and disclosures pertaining to my choice of certain healthcare providers, and 3) that the Plan and Affiliated organizations have contracted through a third party to negotiate with certain healthcare facilities to provide these services on a negotiated basis. I further acknowledge that coverage shall become effective only if approved by the Plan Sponsor/Administrator and only for services which are rendered on or after the effective date of coverage. A photocopy of this authorization shall be as effective and valid as the original. Please maintain a copy of this authorization for your records.

Applicant Print: _____ Applicant Signature: _____ Date: / /