

Wayne County Four Star – Employee Enrollment Application

NOTE: Shaded Areas for Internal Use Only

1. COMPANY NAME: _____

COMPANY ADDRESS: _____

TO BE FILLED OUT BY EMPLOYER:	Group #	Suffix #	Effective Date of Coverage
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2. EMPLOYEE AND MARRIED SPOUSE DATA (All dependents must be listed)

Employee's Last Name	First	Middle Initial	<input type="checkbox"/> Male	<input type="checkbox"/> Female
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Home Address	City	State	Zip	Phone Home ()	Phone Work ()
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Division/Employee No.	Avg. Hours Worked per Week	Date of Hire	Occupation
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IMPORTANT -- List family members for which you are applying. Legal first name and middle initial only – Last name if it is different from yours.

NAME AND INITIAL	SOCIAL SECURITY NUMBER	BIRTH DATE	SEX	RELATIONSHIP CODES* (See codes below)
EMPLOYEE				
SPOUSE				

Insurer may cancel coverage of the employee if:

- Employee is not a regular employee working an average of 20 hours or more per week for the past 90 days.
- Employee is eligible for Medicare, Medicaid or other employer-paid health insurance coverage.
- Employee fails to make premium payments through their employer.
- Employee does not promptly provide information about adding or deleting employees from its insurance plan. (Insurer has the right to seek restitution from employer for any damages it incurs as a result of failure to report.)
- Employee fails to provide any other information the insurer needs to administer payment of benefits within 30 days from date of request.
- The Wayne County Four Star Health Program fails to make timely payment of its 1/3 share of the premium

I have read and understand the above provisions participation in the Wayne County Four Star Health Insurance Program.

X _____ / _____ / _____
 Employee's Signature DATE (Month Day Year)

RELATIONSHIP CODES:

SP – Spouse

<p>Does anyone listed above have other health care Coverage? If so, complete the following:</p> <p><input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT</p> <p>Type of Coverage</p> <p><input type="checkbox"/> BCBS</p> <p><input type="checkbox"/> OTHER _____</p> <p><input type="checkbox"/> MEDICARE No.: _____</p> <p>Effective Date for PART A: _____</p> <p>Effective Date for PART B: _____</p>	<p>Have you or any of your dependents previously been a Health Alliance Plan member?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>NAME: _____</p> <p>FORMER HAP#: _____</p> <p>Have you or any of your dependents previously been an Alliance Health and Life member?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>NAME: _____</p> <p>FORMER ALLIANCE #: _____</p>	<p>Are you to provide medical coverage for a child(ren) listed above according to a qualified medical child support order (QMCSO)?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(IF YES, PLEASE ATTACH DOCUMENT)</p> <p>Does a qualified medical child support order (QMCSO) exist for any dependent child(ren) listed on this application?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(IF YES, PLEASE ATTACH DOCUMENT)</p>
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NOTE: COVERAGE IS AVAILABLE ONLY FOR EMPLOYEE AND MARRIED SPOUSE. IF SPOUSE IS ELIGIBLE FOR MEDICARE, MEDICAID, COMPERABLE EMPLOYER PAID COVERAGE, OR CURRENTLY IN THE U.S. ARMED FORCES THEY ARE NOT ELIGIBLE FOR COVERAGE. CHILDREN ARE NOT ELIGIBLE FOR COVERAGE THROUGH WAYNE COUNTY FOUR STAR HEALTH PROGRAM. COVERAGE FOR CHILDREN MAY BE AVAILABLE THROUGH MI-CHILD OR MICHIGAN MEDICAID.

▶▶ FORM CONTINUED ON REVERSE! ▶▶

APPLICANT SHOULD RETAIN THIS PRE-NOTIFICATION

Alliance Health and Life Insurance Company * Detroit, Michigan 48202

Information given in your application may be made available to other insurance companies to which you make application for life or health coverage or to which a claim is submitted. Information you provide will be treated as confidential except that the above-named company may, however, make a brief report to the Medical Information Bureau (M.I.B.) a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member company to which you have applied for life or health coverage, or to which a claim is submitted, the M.I.B. will supply such company with the information it may have in its files. Upon receipt of a request from you, the M.I.B. will arrange disclosure of any information it may have in your file (medical information will be disclosed only to your attending physician). If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Telephone number (617) 426-3660. The above-named company may also release information in its file to other insurance companies for providers of similar benefits to whom you may apply for life or health coverage, or to whom a claim for benefits may be submitted.

NOTICE – As required by the Federal Fair Credit Reporting Act

In making this application for benefits, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this information.

IMPORTANT NOTICE

The policy for which you are making application has requirements for precertification prior to receiving certain types of treatments. It is the insured's responsibility to initiate certification by calling 1-888-477-7587 prior to treatment. Failure to do so will result in a reduction of benefits.

3. MUST be signed below by persons applying for coverage. NOTE: this application remains valid for 45 days from the date signed.

MISSTATEMENT

I HEREBY APPLY for the group benefits for which I am eligible under the policy provided by Alliance Health and Life Insurance Company. I understand and agree that all statements and answers made in this application are true, complete and correctly recorded and constitute the sole basis for the issuance of the benefits applied for in this application. I understand that the requested coverage is subject to approval by Alliance.

RECISION

I FURTHER UNDERSTAND that failure to disclose all information or any misstatement of information as requested in Parts 1, 2, 3 and 4 may be the basis for cancellation of coverage during the first twenty-four (24) months of enrollment.

PRE-CERTIFICATION REQUIREMENTS

I UNDERSTAND that this policy has certain pre-certification requirements which are explained in detail in each employee's certificate booklet. Failure to obtain the required pre-certification will result in reduced benefits.

INFORMATION RELEASE

I AUTHORIZE my employer to make the necessary payroll deductions, if any are required. I CERTIFY I understand the above information to be full, complete and accurate. I AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, or other organization, institution or person, including Alliance's Health Care Center, that has any records of knowledge of my, or my family's health to give that information to insurance companies, including their reinsurers. A photographic copy of this authorization shall be considered to be valid as the original.

X _____ / _____ / _____
 Employee's Signature DATE (Month Day Year)

X _____ / _____ / _____
 Spouse Signature DATE (Month Day Year)

4. Group Health Coverage Waiver (Complete ONLY if you and/or your dependents DO NOT WANT health benefits).

"I hereby certify that the benefits of my employer's Group Benefit Program have been explained to me. I understand the benefits and have been given the opportunity to participate in the program. I voluntarily and intentionally have decided to waive benefits and not participate in the portion(s) of the group insurance benefit plan check below by me. Further, I acknowledge and understand that if, in the future, I and/or my dependents desire to participate and enroll in the program, then it will be necessary for me and/or my dependents to meet any and all eligibility requirements then in effect. If I or my dependents wish to enroll with an effective date outside my groups open enrollment period, we will have to present evidence of insurability. This includes taking and passing a physical examination at my expense."

- For myself and my dependent(s), if any or Other coverage _____
- For my spouse only
- For my children only
- For my dependent(s) only

X _____ / _____ / _____
 Employee's Signature (sign only if waiving benefits) DATE (Month Day Year)

Group #: _____ Certificate#: _____ Effective Date: _____

Medical Plan #:
 Single Spouse Child Family Children Deductible \$ _____

Transfer of Coverage
 Single Spouse Child Family Children Deductible \$ _____

5.

I verify that the above information is accurate to the best of my knowledge and further that the applicant listed above is an active employee eligible for coverage under the Wayne county Four Star Health Program.

X _____ / _____ / _____
 Authorized Employer Representative DATE (Month Day Year)

X _____ / _____ / _____
 Licensed Resident Agent DATE (Month Day Year)

**Applicants should retain
 this portion for
 their records.**