



**alliance health and life  
insurance company**

Return your application and required materials to:  
CSS, Inc.  
WCFS Student Edition  
25600 Kelly Road  
Roseville, MI, 48066

## Wayne County Four Star - Student Enrollment Application

<b>PERSONAL INFORMATION</b>				
Student's Last Name	First	Middle Initial	Male	Female (circle one)
Home Address	City	State	Zip	Home Phone ( ) Cell Phone ( )
Social Security Number	Date of Birth			
Are you employed? <input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, Where Monthly Income \$			
Married? <input type="checkbox"/> YES <input type="checkbox"/> NO	Spouse Name (if applying as dependent)			
Spouse Date of Birth (if applying)	Spouse Social Security Number (if applying)			
Dependent Children? <input type="checkbox"/> YES <input type="checkbox"/> NO	Child's Name(s) (if applying as dependent)			
Child's Date(s) of Birth	Child's Social Security Number(s) (if applying as dependent)			
<b>SCHOOL INFORMATION</b>				
School Name	School Address			
Student Identification Number	Number of credit hours - (current semester)			
<b>VERIFICATION INFORMATION</b>				
I have attached a copy of the following:				
<input type="checkbox"/> Proof of Student Status – a recent registrar letter on school letterhead or paid tuition statement, or current class schedule. <input type="checkbox"/> Proof of income (if employed – a month of pay stubs or other income verification. <input type="checkbox"/> Proof of Residency – a copy of a Drivers License or applicable tax filing that proves residency. <input type="checkbox"/> A copy of the rejection letter from MI child - if adding a dependent child. <input type="checkbox"/> Payment for the first month of coverage of \$93.00 for <i>each individual</i> (student, spouse, and dependent children) applying for coverage - made out to: Alliance Health and Life Insurance Company.				

**I have read and understand participation in the Wayne County Four Star Health STUDENT EDITION Program**

**X** \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Student Signature Month Day Year

<p><i>Does anyone listed above have other health care coverage?</i></p> <p><i>If so, complete the following:</i></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>Medicare #: _____</p> <p>Effective date for PART A _____</p> <p>Effective date for PART B _____</p>	<p><i>Have you or any of your dependents previously been a Health Alliance Plan member?</i></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Name: _____</p> <p>Former HAP#: _____</p> <p><i>Have you or any of your dependents previously been an Alliance Health and Life Member?</i></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Name: _____</p> <p>Former Alliance# _____</p>	<p><b>Are you to provide medical coverage for a child(ren) listed above according to a qualified medical child support order (QMCSO)?</b></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(if yes, attach copy of 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, attach copy of document)</p>
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**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.

**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 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 any section of this form 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 certificate booklet. Failure to obtain the required pre-certification will result in reduced benefits.

**INFORMATION RELEASE**

I CERTIFY and 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 or 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** \_\_\_\_\_ / /  
Student Signature Month Day Year

**X** \_\_\_\_\_ / /  
Spouse Signature (if applying for dependent coverage) Month Day Year

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

**X** \_\_\_\_\_ / /  
Student Signature Month Day Year

**X** \_\_\_\_\_ / /  
Wayne County Four Star Representative Month Day Year

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