HAP and Alliance Health and Life Insurance Company
Membership and Record Change Form

Subscriber Information

Social Security Number	Last Name	First Name	Initial
HAP ID Number	Current Address	City State Zip	❑ Check if New
Phone Number	Group Name	Group ID Number	Group Subgroup Number / Group Class Number

General Changes

❑ Change of Name **From:** Last First Initial	**To:** Last First Initial
❑ I hereby request cancellation of my coverage for myself and all dependents effective: Month Day Year	
❑ Send Duplicate ID Cards	❑ Send Duplicate Copy of Contract

Add Members to Contract/Additions

	Date of Event			Name		Sex		Social Security Number	Date of Birth		
	Mo.	Day	Year	Last	First	M	F		Mo.	Day	Year
❑ Marriage											
❑ Birth of Child											
❑ Child by Adoption											
❑ Child by Guardianship (Ward)											
❑ Other											

Personal Care Physician (PCP) | PCP Code/NPI

❑ Check if any members listed are a permanently disabled dependent. List name(s) in Additional Information box below. See other side for definition.

Additional Information

Remove Members from Contract/ Deletions

	Date of Event			Name		Sex		Date of Birth
	Mo.	Day	Year	Last	First	M	F	
Death of: ❑ Subscriber ❑ Member								
❑ Divorce								
❑ Other								

Additional Information

❑ Mail Conversion Information to: Address City State Zip

Duplicate Coverage

Are you, your spouse or dependents covered under any other group medical, pharmacy or vision/dental plan (including your spouse's employer)? ❑ Yes ❑ No

Are any of your dependents included in a divorce decree ordering health care coverage? ❑ Yes ❑ No

Name and social security number of parent(s) ordered to provide coverage _____

(Attach a copy of the order if not already on file). _____

If you answered yes to either question above, fill in the information below. If applicable, note which dependent(s) is covered under the court order.

	Name of Employer Include address and phone	Name of Insurance Carrier Include address and phone	Policy Number(s)	Person(s) Covered
Medical				
Pharmacy				
Vision/Dental				

Medicare Updates

Complete for yourself and each family member covered under Medicare.	Birth Date			Medicare ID Number	Effective Dates Part A			Part B		
	Mo.	Day	Year		Mo.	Day	Year	Mo.	Day	Year
Last Name First Name										
Last Name First Name										

Medicaid Updates

Complete for yourself and each family member covered under Medicaid.	Birth Date			Recipient ID Number	Effective Dates		
	Mo.	Day	Year		Mo.	Day	Year
Last Name First Name							
Last Name First Name							

I certify that the above information is correct to my knowledge and belief.

Subscriber's Signature _____ **Month** _____ **Day**_____**Year** _____

Purpose and Instructions

This form should be completed to report all membership and record changes to Health Alliance Plan (HAP)/Alliance Health and Life Insurance Company (Alliance). One copy must be submitted to HAP, Membership and Billing, 2850 West Grand Boulevard, Detroit, Michigan 48202. You can also fax a copy to (248) 443-8175 or send by email to MB_Enrollment@hap.org.* A copy should be retained either in the group membership file or by the subscriber, whichever is appropriate. The form should be signed and dated within 30 days of the event requiring the membership or record change. Updates to your account can be reviewed on the member or group portal. Group subscribers note: this form must be submitted with the first statement following the event requiring the change, otherwise coverage may be delayed. Except for the signature, please type or clearly print all entries. The following guidelines may be useful in completing this form:

General Changes

Change of Name	Enter the new name. The former name should also be entered on the top line of the form.
I Hereby Request Cancellation of My Coverage	Groups should not use this section to indicate termination of employment. Note to Groups: This box should be used for voluntary cancellation of coverage by the employee. Termination of employment should be noted on the monthly statement.

Add Members to Contract/Additions

Marriage	Report the addition of a wife/husband within 30 days of the event.
Birth of Child	Report within 30 days of the birth date.
Child by Adoption**	Report within 30 days of the adoption or placement for adoption.
Child by Guardianship (Ward)**	Report within 30 days of the appointment of the guardian.
Other	Use this area for requesting the addition of any other eligible dependent not listed above. Then complete the “additional information” section described below and include supporting documentation. Visit **hap.org/membershipchange** for a complete list of qualifying events.
PCP Code/NPI	You can obtain this number through the online provider lookup at **hap.org/doctors**. Search for your physician, then click, “more about this provider.”
Permanently Disabled Dependent**	This means a person is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. See your subscriber contract/policy for additional requirements.
Additional Information	Use this area to provide information for any “other” dependent(s). Or when adding more than one dependent. Identify the event, the date the event occurred and give the last and first name, date of birth and social security number of the “other” dependent(s).

Remove Members from Contract/Deletions

Death of Subscriber or Member	Give the name of the deceased and date of death.
Divorce	Give the name of the divorced spouse and date of divorce. Under “additional information,” indicate if coverage for the child(ren) is to be continued on the subscriber’s contract/policy or on a contract/policy issued to the divorced spouse. Be sure to include the social security number and address of the divorced spouse.
Other	Use this area for requesting the deletion of any other dependent not covered above. Then complete the “additional information” section described below.
Additional Information	Use this space to include the names, addresses, social security numbers and other information specifically requested under other areas of this section.
Mail Conversion Information to:	Give the address of any member that has been removed from your coverage for reasons noted in this section and to whom a conversion contract/policy should be sent. If there is more than one member removed, indicate these former members along with their names, addresses and social security numbers under “additional information.”

***This form contains Personal Confidential Information. If sent to HAP by email, it must be encrypted. If you are not able to encrypt, DO NOT email the form. For assistance, contact HAP.**

**Additional information documentation will be required.