2016 Special Enrollment Period and Change Form for Existing Members - PPO Health Plans (Off Marketplace)

Use this form if you qualify for a Special Enrollment Period and need to make changes to, or enroll in, a PPO health plan. If you would like to select an HMO health plan, you will need to complete the 2016 Special Enrollment Period and Change Form for Existing Members - HMO Health Plans. Anyone currently enrolled in Medicare is not eligible to enroll in a HAP Personal Alliance health plan. Please call HAP at (800) 944-9399 for assistance. If you qualify for a special enrollment period, changes to your existing plan must be requested within 60 days of the qualifying life event. Documented proof of the qualifying life event must be included with this form.

Subscriber Information

Social Security Number	Last Name	First Name	Middle Initial

Phone Number	Cell Phone Number	Current Address	City	State	Zip	❑ Check if New

ID Number (See ID card)	Group ID (See ID card)

General Changes

❑ Change of Name **From:** Last First Initial **To:** Last First Initial

❑ Send Duplicate ID Cards

❑ Send Duplicate Copy of Contract

❑ I _____ (subscriber) request cancellation of the health care coverage under the above ID for myself and all dependents effective on the last day of the month listed:
Month Year

❑ I _____ (adult dependent) request cancellation of my health care coverage under the above ID number effective on the last day of month listed:
Month Year

Note: If premium is not paid up to this date, cancellation of coverage will be effective on the last day of the month for which your premium has been paid.

Qualifying Life Events

	Date of Event mm/dd/yyyy	Name Last, First	Sex M	Sex F	Social Security Number xxx-xx-xxxx	Date of Birth mm/dd/yyyy	Tobacco Use in last 6 months Y	Tobacco Use in last 6 months N	Member Add	Member Remove
Marriage										
Birth of Child/Child by Adoption										
Loss of dependent or dependent status due to divorce, legal separation or death										
Non-Calendar Year Policy Renewal										
Permanently moving to a new area that offers new QHP options										
Loss of other coverage										
Death of ❑ Subscriber ❑ Member										
Divorce										

Are any of your dependents included in a divorce decree ordering health care coverage? ❑ Yes ❑ No
(Attach a copy of the court order if not already on file).

Other (please explain)

Pediatric dental coverage will automatically be added for dependents age 18 and under unless attested that coverage has been purchased through another carrier. Refer to dental options on reverse side.

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

Additional Information

Duplicate Coverage

Are you, your spouse or dependents covered under any other medical, pharmacy or vision/dental plan (including your spouse's employer)? ❑ Yes ❑ No
If you answered yes, fill in the information below.

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

Plan Changes

Use this section to select a new PPO health plan.
If you would like to select an HMO health plan, you will need to complete the 2016 Special Enrollment Period and Change Form for Existing Members - HMO Health Plans.

Select New Health Plan	Health Plan Name	Plan Type
	Gold	
❑	*HAP Personal Alliance 1500 PPO* In-Network deductible: $1,500 per person; $3,000 per family	PPO
	Silver	
❑	*HAP Personal Alliance 2500 PPO* In-Network deductible: $2,500 per person; $5,000 per family	PPO
❑	*HAP Personal Alliance 3000 PPO* In-Network deductible: $3,000 per person; $6,000 per family	PPO
❑	*HAP Personal Alliance 3500 PPO* In-Network deductible: $3,500 per person; $7,000 per family	PPO
	Bronze	
❑	*HAP Personal Alliance 4500 PPO* In-Network deductible: $4,500 medical/$1,500 prescription per person; $9,000 medical/$3,000 prescription per family	PPO
❑	*HAP Personal Alliance 5000 PPO (HSA)* In-Network deductible: $5,000 per person; $10,000 per family	PPO (HSA)
❑	*HAP Personal Alliance 6850 PPO* In-Network deductible: $6,850 per person; $13,700 per family	PPO
	Catastrophic	
❑	*HAP Personal Alliance 6850c PPO* In-Network deductible: $6,850 per person; $13,700 per family	PPO

If you chose a Health Savings Account (HSA) Plan, please fill out the authorization form below. Otherwise, do not fill out this form.

Request for a Health Savings Account (HSA) (For HAP Personal Alliance 5000 PPO HSA)

AUTHORIZATION FORM

Alliance recommends that you consider establishing a Health Savings Account (HSA) to maximize the benefits of your HAP Personal Alliance high deductible health plan. While you may open a HSA with any institution of your choice, we have arranged for you to be able to establish your HSA health plan and initiate the process of opening a HSA with BenefitWallet™* all in one easy step.

Please complete this form to let us know if you intend to open a HSA with BenefitWallet by providing the authorization as noted below. Alliance will notify BenefitWallet once your high deductible health plan is activated to let them know to initiate the process of opening a HSA for you.

BenefitWallet will then send you a Welcome Kit which includes information about the HSA and account terms and conditions and a signature card that you will need to sign and return to BenefitWallet.

Note: This form is not required as part of your application for a HSA health plan.

❑ Yes, I would like to open a HSA with BenefitWallet. Please have BenefitWallet send me a HSA Welcome Kit and initiate the process of opening a HSA for me! **

I authorize Alliance Health and Life Insurance Company to provide BenefitWallet with information required to establish my HSA, including my name, address and Social Security number once my HSA health plan is activated.

I understand that:

- The information described above is required by BenefitWallet to establish a HSA and is considered Protected Health Information (PHI) pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- In the event that a HSA health plan is not activated in my name, Alliance will not provide BenefitWallet with this information and this authorization will expire
- This authorization is voluntary
- Payment, enrollment or eligibility for my health care coverage will not be affected if I do not sign this form or open a HSA
- I may revoke this authorization at any time before a BenefitWallet HSA is established for me by notifying Alliance by email at **yourhap@hap.org** (if I do revoke this authorization, it will not have any effect on any information received or actions Alliance or BenefitWallet took before they received the revocation)
- Information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the information
- I should retain a copy of this authorization

❑ I plan on establishing a HSA with another institution _____.
(Institution Name)

❑ I do not plan on establishing a HSA at this time.

* The choice of an institution that offers HSAs is solely your choice and Alliance will honor your relationship with the institution you choose. Alliance does not itself undertake to provide financial services, but solely to arrange for the provision of health care services and to make payments to providers for Covered Services received by you under your health plan. Alliance is not in any event liable for any act or omission of the institution providing your HSA or the agent or employee of such institution, including, but not limited to, the failure or refusal to render services to you.

Alliance is not affiliated with or related to BenefitWallet. The relationship between Alliance and BenefitWallet is that of independent contractors and BenefitWallet has no responsibility for the HSA health plan or other insurance benefits provided by Alliance.

**A BenefitWallet Welcome Kit will be sent once your HSA health plan is activated. If this health plan is not approved and activated by Alliance, you will not receive a HSA Welcome Kit.

Dental Options

Existing HAP Personal Alliance members should use this section when updating dental options

If you have not already purchased pediatric dental coverage through a certified stand-alone dental carrier, you must purchase that coverage in order to get a health plan from HAP. In order to simplify this process, HAP has partnered with Delta Dental, a certified stand-alone dental carrier, who will be responsible for providing your dental benefits while HAP will be responsible for providing your medical benefits.

Based on the above, have you purchased pediatric dental from a Health Insurance Marketplace stand-alone dental carrier?

Response Required

❑ Yes ❑ No If no, please select one of the options below.

Options	Add	Remove
Delta Dental – Pediatric & Adult (All covered applicants) Check this box if you have no dependents and want adult coverage or check this box if you already purchased pediatric coverage from another carrier and want adult coverage.	❑	❑
Delta Dental – Pediatric Only (All covered applicants age 18 and under)	❑	❑

HAP Personal Alliance PPO is offered through Alliance Health and Life Insurance Company (Alliance), a wholly owned subsidiary of Health Alliance Plan.

I certify that the above information is correct to the best of my knowledge and to the extent that it differs from prior applications or change forms. The information and/or choices in this form are intended to revise or replace prior information and/or choices.

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

Adult Dependent Signature _____ **Month** _____ **Day**_____**Year** _____

Purpose and Instructions

If you are an existing member, use this form to report any change to membership information on file with us, or to change your plan. There are three ways to submit this form:

- Mail - HAP
  Attention: Membership and Billing/Government Programs
  2850 West Grand Boulevard
  Detroit, Michigan 48202
- Fax - (313) 664-5906
- Email - govenroll@hap.org

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. Please retain a copy for your records. The form should be signed and dated within the specified number of days as detailed below. Updates to your account can be reviewed on the member portal at **hap.org**. Except for the signature, please 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. Submit proof of name changes within 60 days of event.
I Hereby Request Cancellation of My Health Care Coverage	You must notify us in writing if you wish to cancel your HAP Personal Alliance coverage. The request to cancel the entire policy/contract can only be submitted by the subscriber. To cancel dependents (including spouse) age 18 and older, the request must be submitted by the dependent. The cancellation notice can be sent via U.S. mail or email. Cancellation of coverage is effective on the last day of the month for which your premium has been paid.

Qualifying Life Events

Marriage	Report the addition of a spouse within 60 days of marriage. Provide new spouse's personal information. If other dependents are eligible, please indicate under, "additional information." Copy of marriage certificate required.
Birth of Child/Child by Adoption	Report within 60 days. Provide new dependent's personal information. Copy of birth certificate or hospital documentation, adoption certificate or placement papers required.
Loss of Dependent or Dependent Status due to Divorce, Legal Separation or Death	Report within 60 days. Copy of divorce decree, legal separation papers or death certificate required.
Non-Calendar Year Policy Renewal	Report within 60 days. Copy of renewal letter required.
Permanently Moving to a New Area That Offers New QHP Options	Report up to 60 days before or after the date of the move. Provide information on the person moving. Proof of prior address and change of address required. Subscriber and all dependents on the contract must reside in Michigan and live within the service area of the plan enrolled in to maintain coverage.
Loss of Other Coverage	Report within 60 days. Provide personal information for person losing coverage. • Job loss - provide a copy of proof of loss of coverage. • Aging off parent's plan - provide proof of date of birth, copy of driver's license or passport and proof of loss of coverage. • Losing Medicaid or CHIP coverage - provide a letter from Medicaid/CHIP. • COBRA coverage ending - provide proof of loss of coverage.
Death of Subscriber or Dependent	Provide the name and information of the deceased and date of death within 60 days of death. Copy of death certificate is required and proof of loss of coverage.
Divorce	Provide the name and information of the divorced spouse and date of divorce within 60 days of divorce. Under "additional information," indicate if coverage for the other dependents is to be continued on the subscriber's contract/policy or on a contract/policy issued to the divorced spouse. Copy of divorce decree and proof of loss of coverage is required.
Other	Use this area for any qualifying life event not listed on the form. Please provide full details and date of the event when applying (additional proof may be required).
Tobacco Use	Tobacco use applies to any applicant over the age of 18 who uses tobacco products regularly (four or more times per week), excluding those for religious or ceremonial use. If you use for religious or ceremonial use, please explain using the additional information section on the first page.
Permanently Disabled Dependent Eligibility	A permanently disabled child of the Applicant (or Applicant's Spouse) can be enrolled even if over the age of 26. However, the permanently disabled child over the age of 26 cannot be married, must have been permanently disabled before reaching the age of 26 and must rely upon the Applicant (or Applicant's Spouse) for more than half of their support. Proof of permanent disability is required within 31 days of enrollment.
Additional Information	Use this area to provide additional information as indicated above. For other dependents, identify the event, the date the event occurred and provide the last and first name, date of birth and social security number of the dependent(s).

For assistance, contact HAP at (800) 759-3436.