APPLICATION TO ENROLL IN GROUP HEALTH INSURANCE

ALLEGIANCE LIFE & HEALTH INSURANCE COMPANY, INC.
2806 S. GARFIELD STREET
P.O. BOX 3507
MISSOULA, MT 59806-3507
1-800-737-3137

GINA HEALTH STATEMENT DISCLAIMER

Pursuant to the requirements of the Genetic Information Non-Discrimination Act (GINA), no genetic information is being requested on this application. Genetic information will not be used for any purpose during the application process.

Employee Name:

Statement of HIPAA Portability Rights

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment according to the Special Enrollment provisions of your plan (usually within 30 or 60 days). (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible. If you need but have not received a certificate for past coverage contact Allegiance Life & Health Insurance Company, Inc.
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Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool). To be an eligible individual, you must meet the following requirements:

- - Your most recent coverage was under a group health plan;
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status.

I ACKNOWLEDGE that I have read the statement of HIPAA Portability Rights.

I have prior creditable coverage ❑ YES ❑ NO. If yes, I understand I must submit a certificate of creditable coverage to Allegiance Life & Health Insurance Company, Inc.

Allegiance℠
Life & Health Insurance Company

Employee Name:

APPLICATION TO ENROLL IN GROUP HEALTH INSURANCE (SHORT FORM)

Section 1: Eligible Employee Information			
Employer Name			Date of Hire
Last Name	First Name		MI
Date of Birth (mm/dd/yy)	Social Security Number		Gender ❑ Male ❑Female
Mailing Address			
City	State	Zip	Date of Marriage (if applicable)
Home Phone Number	Work Phone Number	Cell Phone Number	Email Address

Section 2: Spouse/Dependents - Use additional paper if necessary

Last Name, First Name, MI	Social Security Number (required for all enrolling)	Date Of Birth	Gender	Relationship To Employee	To Be Covered? (circle one)
Legal Spouse					Yes / No
Dependent					Yes / No
Dependent					Yes / No
Dependent					Yes / No
Dependent					Yes / No
Dependent					Yes / No

Eligible Dependent *means a legal spouse, a domestic partner that meets the eligibility requirements outlined in the benefit plan document, a dependent child under the age of 26 who is either a natural child, stepchild, legally adopted child, or a child placed with the applicant for adoption.*

Any covered dependent over the age of 18 that does not reside with the applicant should submit a signed Change of Address Form to ensure that mail containing protected health information is sent to the appropriate address.

If you are waiving *Employee* coverage for *any* reason, it is required that you complete the separate Waiver of Health Coverage Form.

Reason for waiving *Dependent* coverage (if applicable**):**

❑ Other coverage(s): Insurance Carrier Name (s)_____

❑ Other reason(s) - (please explain) _____

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date. Specifically, except during applicable "Special Enrollment Periods", each person listed above may be considered to be a Late Enrollee.

Employee Name:

Section 3: Other Health Insurance Information: (This section is *required* for claims processing)			
Other Health Coverage?* ❑ Yes (complete below) ❑ No ***Please complete the fields below if you are going to continue to have coverage through another carrier in addition to this coverage.**			
Please check the coverage currently being provided elsewhere: ___ Medical ___ Pharmacy ___ Dental ___Vision List all family members, including yourself, who will continue to have coverage through another carrier in addition to this plan:			
Self: □ Yes □ No	**Spouse:** □ Yes □ No (If yes, continue below)	**Child(ren):** □ Yes □ No (If yes, continue below)	
SPOUSE:	Date coverage will end:	CHILD:	Date coverage will end:
CHILD:	Date coverage will end:	CHILD:	Date coverage will end:
CHILD:	Date coverage will end:	CHILD:	Date coverage will end:
Name, Phone Number and Address of other insurance company:		Policy/Certificate Number:	Effective Date:
Policyholder's Name:		Social Security Number:	Date of Birth:

If you and/or your dependents are enrolled in Medicare Part A, Part B, and/or Part D, or Medicaid, please complete the following fields:

Enrollee's name(s):	Medicare or Medicaid ID#:	Medicare Part A Effective Date:	Medicare Part B Effective Date:	Medicare Part D Effective Date:	Medicaid Effective Date:

IF PARENTS OF DEPENDENT CHILD(REN) WERE NEVER MARRIED, OR IF THEY ARE NOW SEPARATED OR DIVORCED: Please answer the following questions for dependent children in order to determine which coverage has primary liability.

Date of divorce or separation (if applicable):	Is there a court order making one parent responsible for the child's medical, dental, or vision expenses? □ Yes □ No ***If yes, please provide a copy of the divorce decree or parenting plan.**

Which parent has physical custody of the child? Name _____ DOB _____

Has the parent with custody remarried? □ Yes □ No

If yes, does the step-parent cover this child? □ Yes □ No *If yes, please provide insurance information below:

Name, Phone Number and Address of other insurance company:	Policyholder's Name: Policyholder's Date of Birth:	Policy/Certificate Number:

Effective Date of Coverage: Termination Date of Coverage (if applicable):	Type of Coverage: ❒ Medical ❒ Prescription ❒ Dental ❒ Vision	Members on the Plan:

Employee Name:

Section 4: Employee/Policyholder Information (To Be Completed By Employer)	
Name of Group/Employer	Group Number
Name of Employee	Occupation
Current Number of Hours Per Week	Date employee started working the required number of hours to become eligible for coverage:
Group Leader (please print)	Signature of Group Leader Date

Section 5: Conditions of Enrollment

I/We UNDERSTAND that providing false, incomplete, inaccurate or incorrect information to any of the questions on the Enrollment Form may be considered insurance fraud and may result in denial or cancellation of coverage from its beginning.

I HEREBY AUTHORIZE my employer to make any required payroll deductions for this coverage. I certify that the information provided is true and correct.

This is an application only. No right is given to me or any person listed on this application until Allegiance Life & Health Insurance Company, Inc. accepts me/us and premiums are paid.

I/We personally completed the Medical History section of this form, providing all requested information.

All statements made are true and complete for me and for each person applying for coverage.

Each person applying for coverage is in good health, except for those conditions listed.

Information regarding your insurability will be treated as confidential. Allegiance Life & Health Insurance Company, Inc. or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. 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 P O Box 105, Essex Station, Boston, MA 02112, telephone number 617-426-3660.

Allegiance Life & Health Insurance Company, Inc. or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted."

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Allegiance Life & Health Insurance Company, Inc. or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original.

Section 6: Signature

I/We understand and agree that the coverage I/We am/are applying for is subject to the group eligibility and enrollment requirements. I/We have read the Conditions of Enrollment. I/We understand and agree to them.

Must also have signature(s) of spouse and/or all dependent(s) 18 and over if applying

Employee Signature	Date
Spouse Signature	Date
Dependent Signature (18 or older)	Date
Dependent Signature (18 or older)	Date
Dependent Signature (18 or older)	Date

Employee Name:

SPACE LEFT FOR FURTHER INFORMATION IF APPLICABLE

ALLEGIANCE LIFE & HEALTH INSURANCE COMPANY, INC.
2806 S. GARFIELD STREET
P.O. BOX 3507
MISSOULA, MT 59806-3507
1-800-737-3137

Employee Name:

WAIVER OF GROUP HEALTH INSURANCE FORM

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Allegiance℠
Life & Health Insurance Company

Employee Name:

WAIVER OF GROUP HEALTH INSURANCE FORM

Employee Information		
Employer Name		Date of Hire
Last Name	First Name	MI
Date of Birth (mm/dd/yy)	Social Security Number	Gender ❑ Male ❑Female

Spouse/Dependents - Use additional paper if necessary			
Last Name, First Name, & MI	Gender	Relationship To Employee	To Be Covered?
Legal Spouse			No
Dependent			No
Dependent			No
Dependent			No
Dependent			No
Dependent			No

Waiving Coverage

I <u>decline</u> to enroll in the health coverage for: ❑ Myself ❑ My Spouse ❑ My Dependent Child/Children

Reason for waiving coverage:

❑ Other coverage(s) – Insurance Carrier Name (s) _____

❑ Other reason(s) - (please explain) _____

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Employee's Signature_____ Date Signed_____

Spouse's Signature_____ Date Signed_____

Employee Name:

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