2017 Personal Alliance HMO Application

Enclosed is the application for your HAP Personal Alliance® HMO health plan. In order to avoid delays in the application process, please fill out the form completely and write clearly.

Please make sure you include information for each person that will be covered on your plan before sending it back. This information is required of all applicants, including those who have experienced a qualifying life event and are applying during a special enrollment period.

You can choose from these health plan options:

- HMO: A primary care physician within the network coordinates all of your health care needs.
- Choice HMO: You'll receive care from a select range of doctors who participate in the same network.
  - Genesys Choice network: This network is available to residents of Genesee County.
  - Henry Ford Choice network: This network is available to residents of Macomb, Wayne and Oakland counties.[1]
- Health savings account: An individually owned bank account to help pay for medical expenses that is paired with a HMO plan.

To compare plans and apply online, visit **hap.org/plans**. To find out if your doctor is part of our network, visit **hap.org/doctors**.

How to apply:

1. Complete all fields on the attached application. Write "N/A" in fields that do not apply to you.
2. Select one health plan.
3. Select the pediatric dental benefit (unless you've already purchased pediatric dental coverage).
4. Select the optional adult dental benefit (if desired).
5. Complete all details for each person you would like to include on your plan.

If you are applying due to a qualifying event, you must apply within 60 days of when the life event occurs. The effective date will be assigned upon review. Proof of the qualifying life event must also be sent to us, along with your application, by mail, email or fax. Refer to the application to see which documents are required.

When finished, please print application, sign and return with any supporting documentation[2] to:

Mail: HAP
Attention: HAP Personal Alliance
26877 Northwestern Highway, Suite 420
Southfield, MI 48033-9903

Fax: (248) 552-0228

Or you can email your application by scanning the completed document and sending an encrypted copy to **hap@personalalliance.org.** The application must be encrypted when emailed because it contains personal and confidential information. **If you cannot encrypt it, do not email the application.**

[1]Excludes the following ZIP codes in Oakland County: 48346, 48348, 48350, 48353, 48356, 48357, 48359, 48360, 48362, 48367, 48370, 48371, 48428, 48430, 48439, 48442, 48455 and 48462.

[2]Additional documentation is only required for applicants who are applying during a qualifying life event.

If you have questions, please contact your agent or call us at **(855) WITH-HAP** (948-4427) or TTY: 711. We're available Monday through Friday from 8 a.m. to 6 p.m.

We look forward to working for you!

HAP Personal Alliance HMO is offered through HAP, a state-certified health maintenance organization.

Health Alliance Plan (HAP)
2017 Individual and Family Medical Coverage Application Form for HMO and HSA Products

Personal Alliance®

Application Date: _____ (mm/dd/yyyy)

Primary Applicant Name: _____

- Apply 11-1-2016 through 12-15-2016 and your effective date will be 1-1-2017
- Apply between the 1st and 15th of the month and your effective date will be the 1st of the following month
- Apply between the 16th and the end of the month and your effective date will be the 1st of the second following month
- For Special Enrollment Periods the effective date will be assigned upon review

How did you hear about us? **Please select all that apply.**

- ☐ Web Search
- ☐ Email
- ☐ Personal Experience
- ☐ Agent
- ☐ Facebook, Twitter, LinkedIn or other social network
- ☐ Event
- ☐ Radio
- ☐ TV
- ☐ Magazine or Print Ad
- ☐ Chamber of Commerce
- ☐ Family or Friend Referral
- ☐ Other

Why did you select a HAP Personal Alliance health plan? **Select only one.**

- ☐ Price
- ☐ Plan Benefits
- ☐ Recommendation
- ☐ Customer Experience
- ☐ Network of Doctors and Hospitals
- ☐ Company Reputation
- ☐ Previous HAP Member

If you are applying through an agent, what is his/her name?: _____

Agent Phone Number: ( ) _____ Agency Name: _____

Why are you applying? (Select only one)

☐ Applying for coverage during annual open enrollment

☐ Applying due to a qualifying life event **(Please note: If you qualify for a special enrollment period, you must apply for a new health plan within 60 days of the life event. Documentation supporting the qualifying life event must be included with your application.)**

Please check the box below that represents the qualifying life event (Select only one)

☐ Marriage (copy of marriage certificate required)

Date of event:_____

☐ Birth of child (copy of birth certificate or hospital documentation required)

Date of event:_____

☐ Adoption/Placement for adoption of child (copy of adoption certificate/placement papers required)

Date of event:_____

☐ Divorce/Legal Separation/Death (copy of divorce decree, legal separation papers or death certificate required)

Date of event:_____

☐ Non-Calendar Year Policy Renewal (copy of renewal letter required)

Date of event:_____

☐ Permanently moving to a new area that offers new QHP options (proof of prior coverage within 60 days, prior address and new/current address required)

Date of event:_____

Loss of other coverage:

Voluntarily cancelling other health coverage and being terminated for not paying premiums are not considered loss of coverage. Neither is losing a plan that does not carry minimum essential coverage.

☐ Job Loss (proof of loss of coverage required)

Date of event:_____

☐ Loss of group health coverage (proof of loss of coverage required)

Date of event:_____

☐ Divorce (copy of divorce decree and proof of loss of coverage required)

Date of event:_____

☐ Death (copy of death certificate and proof of loss of coverage required)

Date of event:_____

☐ Aging off a parent's plan (proof of date of birth or copy of driver's license or copy of passport and proof of loss of coverage required)

Date of event:_____

☐ Losing Medicaid or CHIP coverage (copy of letter from Medicaid or CHIP required)

Date of event:_____

☐ COBRA coverage ending (proof of loss of coverage required)

Date of event:_____

☐ Other (give details and provide supporting documentation) _____

Date of event:_____

Your effective date will be assigned after we review your completed application.

Select One Health Plan:

Select Plan	Plan Marketing Name	Plan Type
GOLD TIER		
☐	HAP Personal Alliance 1000 HMO Henry Ford Choice	HMO
SILVER TIER		
☐	HAP Personal Alliance 2500 HMO Henry Ford Choice/Genesys Choice	HMO
☐	HAP Personal Alliance 2500 HMO	HMO
☐	HAP Personal Alliance 2700 HMO HSA Henry Ford Choice/Genesys Choice	HMO
☐	HAP Personal Alliance 2700 HMO HSA	HMO
☐	HAP Personal Alliance 3250 HMO Henry Ford Choice/Genesys Choice	HMO
☐	HAP Personal Alliance 3250 HMO	HMO
BRONZE TIER		
☐	HAP Personal Alliance 5000 HMO Henry Ford Choice/Genesys Choice	HMO
☐	HAP Personal Alliance 5000 HMO	HMO
☐	HAP Personal Alliance 5500 HMO HSA Henry Ford Choice/Genesys Choice	HMO
☐	HAP Personal Alliance 5500 HMO HSA	HMO
☐	HAP Personal Alliance 6550 HMO HSA Henry Ford Choice/Genesys Choice	HMO
☐	HAP Personal Alliance 6550 HMO HSA	HMO
CATASTROPHIC TIER		
☐	HAP Personal Alliance 7150 HMO Henry Ford Choice/Genesys Choice	HMO
☐	HAP Personal Alliance 7150 HMO	HMO

On January 1 of each year, plan offerings will be re-determined and all cost-sharing (including deductibles and out-of-pocket limits) will start over.

Select Your Delta 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 medical 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 an exchange certified stand-alone dental carrier?

☐ Yes ☐ No

Select Option	Options
☐	Delta Dental – Pediatric & Adult Check this box if you are purchasing dental coverage for all applicants listed on this application
☐	Delta Dental – Pediatric Only Check this box if you are purchasing dental coverage only for applicants listed on this application age 18 and under

Please tell us about each person to be covered under this plan:

Primary Applicant Information

First Name, MI, Last Name	Gender M/F	Relationship Code (See Codes Below)	Date of Birth (mm/dd/yyyy)	Social Security Number xxx-xx-xxxx	Marital Status M/S	Tobacco Use* (over last six months)	Are you currently enrolled in Medicare
						☐ Y ☐ N	☐ Y ☐ N

Dependent Information (Spouse and other family members under age 26 unless permanently disabled)

First Name, MI, Last Name	Gender M/F	Relationship Code (See Codes Below)	Date of Birth** (mm/dd/yyyy)	Social Security Number xxx-xx-xxxx	Marital Status M/S	Tobacco Use* (over last six months)	Are you currently enrolled in Medicare
						☐ Y ☐ N	☐ Y ☐ N
						☐ Y ☐ N	☐ Y ☐ N
						☐ Y ☐ N	☐ Y ☐ N
						☐ Y ☐ N	☐ Y ☐ N

*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 yes, please explain:

_____

_____

Relationship Codes:

M - Subscriber **W** - Wife/Spouse **H** - Husband/Spouse

S - Son (Dependent) **D** - Daughter (Dependent) **HD** - Permanently Disabled (Dependent)

** 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. We require proof of permanent disability within 31 days of enrollment.

Primary Applicant's Information (Please provide ALL information; P.O. boxes not accepted)

Street Address: _____ APT#: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone Number: ( ) _____ Cell Phone: ( ) _____

(Required Field) Email Address: _____

The primary applicant along with their spouse and/or dependents identified above, are all considered applicants for purposes of this application.

Other Medical Coverage

Do any of the applicants have major medical coverage through another company? ☐ Y ☐ N

Do you plan to keep any coverage other than the plan you are purchasing now? ☐ Y ☐ N
If so, please complete the information below.

Subscriber(s) Name(s): _____ Subscriber(s) Date of Birth: _____
(mm/dd/yyyy)

Name of medical coverage carrier: _____

Contract Number: _____

Additional Information

Please provide any information below that you would like included with your application.

_____
_____
_____
_____
_____
_____

Billing Information

If payment for coverage is made by a third party other than the primary applicant, the following shall all result:

1. The primary applicant shall remain financially responsible for payment if an account transfer or credit card is declined.
2. By making payment, the third party shall have no formal rights recognized by HAP concerning coverage.
3. Any legal refund or adjustment of premiums or other financial settlement will be delivered to the primary applicant and not to the third party.

Payment Options: (Please select one of the payment options below)

☐ Payment Option 1: Credit Card Authorization

I authorize HAP to charge/debit my credit card account for the payment of my premium bill, including any taxes and fees. HAP will deduct the net balance due on the account each month based on the premium amount communicated to me. If the payment date falls on a weekend or holiday, I understand that the payments may be executed on the next business day. I also understand that I am solely responsible for ensuring that adequate funds are available. I agree to permit HAP to debit and credit my account as appropriate for payments and error resolution and to hold HAP harmless for any fees or penalties that may arise due to not having sufficient funds in my account. I certify that I am an authorized user of this credit card account. I understand that this authorization will remain in effect until I notify HAP in writing to cancel. I can cancel this authorization and stop payment by notifying the Membership and Billing department at 2850 West Grand Boulevard, Detroit, MI 48202 thirty (30) days before my account is charged.

Paper applications must **only** be sent to the mailing address on the application cover sheet. If sending electronically **only** use the email address provided on the cover sheet.

Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Cardholder Name (as Printed on Card): _____

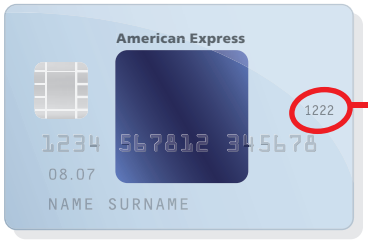
Card Number: _____

Expiration Date:_____

Security Code No:_____
(Located on back/front of card depending on type of card used)

Zip Code:_____

Signature of Authorized User: _____



☐ Payment Option 2: Electronic Funds Transfer (EFT) Authorization

I authorize HAP to withdraw funds from the bank account listed below for the payment of my premium bill, including any taxes and fees. HAP will deduct the net balance due on the account each month based on the premium amount communicated to me. If the payment date falls on a weekend or holiday, I understand that the payment may be executed on the next business day. I also understand that I am solely responsible for ensuring that adequate funds are available. I agree to permit HAP to debit and credit my account as appropriate for payments and error resolution and to hold HAP harmless for any fees or penalties that may arise due to not having sufficient funds in my account. I certify that I am an authorized user of this bank account. I understand that this authorization will remain in effect until I notify HAP in writing to cancel. I can cancel this authorization and stop payment by notifying the Membership and Billing department at 2850 West Grand Boulevard, Detroit, MI 48202 thirty (30) days before my account is charged.

Account Type: ☐ Checking

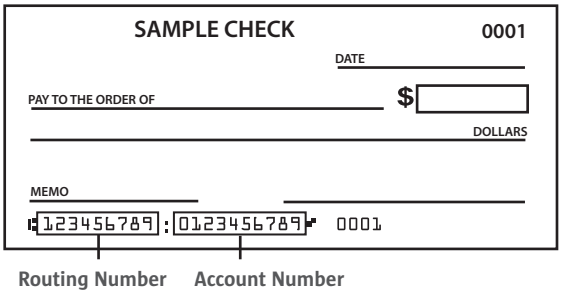
Name on Account: _____

Bank Name: _____

Bank Routing Number: _____

Account Number: _____

Optional: Bank City/State: _____



☐ Payment Option 3: Bill Me

The invoice will be sent to the primary applicant's address listed on this application.

If you selected a plan with a Health Savings Account (HSA), please fill out the authorization form on the following page. Otherwise, do not fill out this form.

Request for a Health Savings Account (HSA)
(For HAP Personal Alliance 2700 HMO HSA/5500 HMO HSA/6550 HMO HSA)

AUTHORIZATION FORM

HAP 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. HAP 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.

Eligibility for a HSA is determined by Federal law. It is your responsibility to ensure that you are eligible.

To be eligible for a HSA account you must meet the following criteria:

- You must not be covered by any other health insurance (other than another Consumer Driven Health Plan), including coverage through The Canada Health Act
- You must not be eligible or claimed on another person's tax return
- You must not be enrolled in Medicare

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 Health Alliance Plan 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, HAP 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 HAP by email at yourhap@hap.org (if I do revoke this authorization, it will not have any effect on any information received or actions HAP 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 HAP will honor your relationship with the institution you choose. HAP 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. HAP 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.

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

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

Agreement and Signature

By executing this application all applicants understand, agree and represent all of the following without limitation:

1. We have read this application or it has been read to us and we understand its terms and conditions.
2. The answers are, to the best of our knowledge, true and complete.
3. In some instances, a follow-up telephone call and/or email may be required to verify information provided in this application.
4. We may be required to provide proof of eligibility (marriage, divorce, birth, adoption, loss or addition of other coverage) satisfactory to HAP as a condition of acceptance of this application and the issuance of a subscriber contract. HAP must be notified of any of these events that might change an applicant's eligibility for coverage. Notice must be received within 31 days of the event in order to provide coverage, terminate coverage and/or adjust premiums. HAP must be notified within 31 days of any change in name, address, email address or telephone number, eligibility or entitlement to Medicare or Medicaid, or the addition or change in any source of coverage or reimbursement for services related to an accident or injury to which we may be entitled. Failure to provide timely and complete notice of changes as noted above may result in a lapse in coverage and nonpayment of services. HAP is not responsible for a lapse in coverage when notice is not provided.
5. We have received and reviewed any state or federal required disclosures.
6. We do not have the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any HAP requirement.
7. The coverage applied for is not an employer-sponsored group health plan and it does not comply with state and federal small employer or other contract laws.
8. We represent that no one applying for coverage is receiving any form of reimbursement or compensation for this coverage from any employer.
9. If we currently have medical coverage through another company, we understand the benefits provided under this coverage may be reduced in accordance with the coordination of benefits provision in the subscriber contract.
10. If this application for coverage is accepted, coverage will be effective on the date specified by HAP on the subscriber contract and we understand that acceptance of premium and fees do not assure coverage.
11. If selected, we have provided authorization for automatic withdrawal from a specified bank account or credit card for premium payment and administrative fees.
12. Premiums already paid will be refunded if a subscriber contract is not issued.
13. Our answers to questions posed by this application are intentional representations of material facts and we understand that should those answers contain fraudulent or false information, coverage may be denied, or subject to rescission if initially issued.
14. If coverage is rescinded, we understand and agree that we will be financially responsible for any medical claims expense incurred on our behalf and that HAP may offset any premiums to be returned to us by an amount not to exceed incurred claims expense.
15. Each applicant waives his/her right to receive a hard copy of their subscriber contract, any applicable rider, this application and schedule of benefits, but understand that he/she will be given a right to specifically request a hard copy of such documents if accepted for coverage. The applicants further waive any right they may have to claim that HAP may not raise issues concerning the accuracy of the statement contained in this application if he/she is not given a hard copy of this application.
16. We understand and agree that required legal notices and communication (including new policies, riders, renewal notifications, and other documents concerning coverage or rights under the policy) may be delivered electronically to the email address designated and not through US mail. We understand that we have the right to paper copies of any and all documents concerning this coverage at no cost and that this consent to electronic communication may be cancelled at any time without charge. Cancellation of this consent can be exercised and requests for paper copies can be sent to: Customer Service at 2850 West Grand Boulevard, Detroit, MI 48202. Updates to the email address can be sent to Customer Service. We understand that in order to obtain electronic documents from HAP's website the Microsoft Internet Explorer 7, 8, 9 or 11 web browser is recommended. If using an Apple computer, the Safari browser is recommended. Viewing PDF files requires Adobe Reader.

17. Any applicants that do not meet the definition of spouse will be split into two contracts. Dependents will remain with the primary applicant unless otherwise directed.
18. We attest that if not purchasing pediatric dental benefits from Delta Dental (through HAP), we will purchase (or have purchased) benefits from an exchange certified stand-alone dental carrier. HAP will rely upon my attestation in order to be reasonably assured that pediatric dental coverage will be purchased. Without this assurance medical coverage will not be provided.
19. We can confirm that no one applying for medical coverage on this application is incarcerated, detained or jailed.
20. We understand that any person currently enrolled in Medicare or incarcerated will not be covered under this contract.

This document, together with any supplements or amendments, will form part of any contract and be the basis for any contract issued.

In order for your paper application to be processed, the HAP Personal Alliance team will input the fully completed and signed paper application into our system. We will electronically sign the application and process payment on your behalf, but the paper application containing your signature will be the controlling legal document. By signing below, you consent to this process. You may revoke your consent at any time through written notice delivered through US Mail, fax or email to Health Alliance Plan, Attn: HAP Personal Alliance, 2850 West Grand Boulevard, Detroit, MI 48202.

Authorization

Those applicants accepted for coverage authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, pharmacy, pharmacy benefit manager, pharmacy related facility, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., producer/agent, employer or the Consumer Reporting Agency having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness and copies of all hospital or medical records, prescription drug records, non-public personal health information and any other non-medical information to share any and all such information with HAP, its reinsurer, its legal representatives and its affiliates.

This authorization will not be used by HAP to conduct a medical underwriting function for the purpose of establishing eligibility or premiums associated with the coverage being applied for.

HAP, or its reinsurers, may release information in its file to other companies to whom you may apply for life or health coverage, or to whom a claim for benefits may be submitted. We understand and agree to the following:

1. The information obtained by use of this authorization may be used by HAP to determine eligibility for coverage, eligibility for benefits under existing coverage, plan administration and to make claim determinations.
2. If the decision is made not to sign this authorization, HAP will decline to enroll us in a medical plan or to give us medical benefits.
3. Any information obtained will not be released by Health Alliance Plan to any person or organization except reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with any application, claim or as may be otherwise lawfully required, or as we may further authorize.
4. Once personal and health information (including medical, dental and pharmacy) information is disclosed pursuant to this authorization it may be re-disclosed by the recipient and the information may not be protected by federal and state privacy requirements.
5. A copy of this authorization is available to us or our legal representative upon written request.
6. A photographic copy of this authorization shall be as valid as the original.
7. This authorization shall be valid until revoked.
8. We have the right to revoke this authorization at any time.
9. To revoke this authorization, we must do so in writing and send written revocation to HAP Membership and Billing Government Programs, 2850 West Grand Boulevard, Detroit, MI 48202 or fax to (313) 664-5906 or email to govenroll@hap.org.
10. The revocation will not apply to information that has already been released in response to this authorization.
11. The revocation may adversely affect our application, a claim or a pending action.
12. The revocation will become effective after it is received by HAP Membership and Billing Government Programs.

Disclosure

Health Alliance Plan does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Please sign, date and mail to:

Health Alliance Plan
26877 Northwestern Hwy, Ste. 420
Southfield, MI 48033-9903
Attn: HAP Personal Alliance

Or scan the completed application and email to hap@personalalliance.org

If you are a broker or agent completing this application on behalf of the Primary Applicant, please read the following attestation, check the box to indicate your agreement, sign below as legal representative and indicate your name and relationship (broker or agent) to the Primary Applicant.

Broker/Agent Attestation:

☐ As a licensed and qualified broker/agent authorized to do business with HAP I attest to the following:

1. I have been given full legal authority through a valid power of attorney to file an application and to make premium payment (if applicable) on behalf of the individuals named in the application;
2. I shall notify HAP if my authority to act on their behalf were to change;
3. HAP is entitled to rely upon this attestation;
4. I have complied with all pertinent provisions of state and federal law in establishing and exercising by broker/agent responsibilities; and
5. I shall be legally responsible for errors and omissions in the application that result from my own negligence or intentional misrepresentation.

If you are the parent or legal guardian completing this application on behalf of a minor child(ren), please read the following attestation, check the box to indicate your agreement, sign below as legal representative and indicate your name and relationship to the Primary Applicant.

Parent or Legal Guardian Attestation (For Child Only Policies)

☐ By signing, the parent or legal guardian agrees to be responsible for paying all premiums, copayments, coinsurance and deductibles for all the applicants listed in this form.

On behalf of all the applicant(s), I attest to the following:

1. I have been given full legal authority to file an application on behalf of, and as a legal representative for, the individuals noted in the application, including the Agreement and Signature, Authorization and Disclosure sections;
2. I shall document my authorization, and upon request will provide this documentation to HAP;
3. I shall notify HAP if my authority to act on their behalf were to change;
4. HAP is entitled to rely upon this attestation; and
5. I shall be legally responsible for errors and omissions in the application that result from my own negligence or intentional misrepresentation.

Any person who submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud.

Primary Applicant or Legal Representative Signature: _____ Date _____
(mm/dd/yy)

Primary Applicant or Legal Representative Printed Name:_____ Date_____
(mm/dd/yy)

Relationship of Legal Representative: _____Date _____
(mm/dd/yy)

Spouse Signature: _____ Date _____
(If applying for coverage) (mm/dd/yy)

Child Signature: _____ Date _____
(If 18 years of age or older and applying for dependent coverage) (mm/dd/yy)

Child Signature: _____ Date _____
(If 18 years of age or older and applying for dependent coverage) (mm/dd/yy)

Child Signature: _____ Date _____
(If 18 years of age or older and applying for dependent coverage) (mm/dd/yy)

Child Signature:_____ Date _____
(If 18 years of age or older and applying for dependent coverage) (mm/dd/yy)

Nondiscrimination Notice

Health Alliance Plan of Michigan (HAP) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

HAP provides:

- Free aids and services to help people communicate effectively with us.
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, others)
- Free language services to people whose primary language is not English
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact HAP's customer service manager in Government Programs at (800) 422-4641.

If you believe that HAP has failed to provide these services or discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with HAP's director of grievance and appeals. Use the information below:

- **Mail:** 2850 West Grand Boulevard, Detroit Michigan, 48202
- **Phone:** (800) 422-4641
  Medicare: (800) 801-1770
  TTY: 711
- **Fax:** (313) 664-5866
- **Email:** msweb1@hap.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- **Online:** Use the Office for Civil Rights' Complaint Portal Assistant at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf.
- **Mail:** U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.
- **Phone:** (800) 368-1019 or TTY: (800) 537-7697.

Complaint forms are also available at **www.hhs.gov/ocr/filing-with-ocr/**.

How to Get Help and Information in Other Languages

This notice has important information about your application or coverage through Health Alliance Plan of Michigan. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. To talk with an interpreter, call (800) 422-4641.

Ky njoftim përmban informacion të rëndësishëm për aplikimin ose mbulimin tuaj nëpërmjet Health Alliance Plan of Michigan. Kontrolloni për data të rëndësishme në këtë njoftim. Mund t'ju duhet të ndërmerrni veprim brenda afateve të caktuara për të mbajtur mbulimin tuaj shëndetësor ose për ndihmën me kostot. Keni të drejtë ta merrni këtë informacion dhe ndihmë falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin (800) 422-4641.

يحوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال Health Alliance Plan of Michigan. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك من دون أي تكلفة. للتحدث مع مترجم فوري اتصل على الرقم 422-4641 (800).

এই বজ্ঞিপ্ততিে Health Alliance Plan of Michigan মাধ্যমে আপনার আবদেন বা কভারজে সম্বন্ধে গুরুত্বপূর্ণ তথ্য আছে। এই বজ্ঞিপ্ততিে গুরুত্বপূর্ণ তারখিগুলি খয়োল করুন। আপনার হলেথ কভারজে ঠকিঠাক রাখতে বা খরচ সম্পর্কতি সহায়তার জন্য আপনাকে নর্দিষ্টি সময়সীমাগুলরি মধ্যে অ্যাক্সন নতিে হতে পার।ে বনিা খরচে আপনার নজিস্ব ভাষাতে সহায়তা পাবার এবং তথ্য জানবার অধকিার আপনার আছ।ে একজন দ·ভাষীর সাথে কথা বলতে, (800) 422-4641 নম্বরে কল করুন।

本通知有關於您透過Health Alliance Plan of Michigan 提交的申請或獲得的保險的重要資訊。請留意本通知內的重要日期。您可能需要在特定截止日期之前採取行動，以保留您的健康保險或者有償幫助。您有權利免費以您的母語得到本資訊和幫助。若要與口譯人員交談，請撥打 (800) 422-4641。

Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch den Health Alliance Plan of Michigan. Beachten Sie mögliche wichtige Stichtage in dieser Benachrichtigung. Unter Umständen müssen Sie bestimmte Fristen einhalten, um Ihren Krankenversicherungsschutz oder die finanzielle Unterstützung beizubehalten. Sie haben das Recht, hierzu kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 422-4641 an.

Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso Health Alliance Plan of Michigan. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero (800) 422-4641.

この通知には、Health Alliance Plan of Michigan の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。通訳とお話される場合、(800) 422-4641 までお電話ください。

본 통지서에는Health Alliance Plan of Michigan을 통한 귀하의 신청내역이나 보험 커버리지에 관한 중요한 정보가 들어 있습니다. 본 통지서에서 핵심이 되는 날짜를 찾으십시오. 보험 커버리지를 유지하거나 비용을 절감하기 위해서는 해당 마감일까지 조치를 취하셔야 합니다. 귀하는 모국어로 된 정보와 도움을 무료로 받을 수 있는 권리가 있습니다. 통역사와 대화하시려면 (800) 422-4641번으로 전화하십시오.

To ogłoszenie zawiera ważne informacje odnośnie do Państwa wniosku lub zakresu świadczeń poprzez Health Alliance Plan of Michigan. Prosimy zwrócić uwagę na kluczowe daty zawarte w tym ogłoszeniu. Konieczne może być podjęcie działań w określonym terminie, aby utrzymać polisę ubezpieczeniową lub pomoc związaną z kosztami. Mają Państwo prawo do otrzymania bezpłatnej pomocy oraz informacji we własnym języku. Aby porozmawiać z tłumaczem, należy zadzwonić pod nr (800) 422-4641.

Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Health Alliance Plan of Michigan. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощи на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 422-4641.

Ova obavijest sadrži važne informacije o Vašoj prijavi ili osiguranju preko Health Alliance Plan of Michigan. Obratite pozornost na važne datume. Možda ćete u određenom roku morati poduzeti radnje kako biste zadržali svoje osiguranje ili pomoć pri pri podmirivanju troškova. Imate pravo na besplatnu pomoć i informacije na svom jeziku. Da biste razgovarali s prevoditeljem, nazovite (800) 422-4641.

Este aviso contiene información importante acerca de su solicitud o cobertura a través de Health Alliance Plan of Michigan. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Para hablar con un intérprete, llame al (800) 422-4641.

ܗܿܝ ܡܫܡܥܢܘܬܐ ܟܐ ܚܒܫܐ ܠܗ ܡܘܕܥܢܘܬܐ ܐܢܝܩܬܐ ܒܘܕ ܦܬܠܬܘܟܘܢ ܝܢ ܬܟܠܬܘܟܘܢ ܒܐܘܪܚܐ ܕܣܘܪܝܐ
ܕ Health Alliance Plan of Michigan. ܚܙܝܘܢ ܒܬܪ ܡܘܥܕ̈ܐ ܐܢܝܩ̈ܐ ܕܟܬܝܒܐ ܠܗ ܓܘ ܗܕܐ ܡܫܡܥܢܘܬܐ. ܒܠܟܐ ܕܗܘܝܐ ܐܢܝܩܘܬܐ
ܕܥܒܕܝܬܘܢ ܡܕܡ ܩܕܡ ܡܘܥܕ̈ܐ ܡܣܘܝ̈ܡܐ ܐܚܪ̈ܢܐ، ܩܐ ܕܟܐ ܛܪܝܬܘܢ ܬܟܠܬܘܟܘܢ ܝܢ ܗܝܪܐ ܕܦܠܛܬܘܟܘܢ
ܐܝܬܠܘܟܘܢ ܙܕܩܐ ܕܫܩܠܝܬܘܢ ܗܕܐ ܡܘܕܥܢܘܬܐ ܘܗܝܪܐ ܒܠܫܢܘܟܘܢ ܡܓܢܐܝܬ. ܠܡܡܠܠܐ ܥܡ ܚܕ
ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܕܬܠܝܦܘܢ (800) 422-4641.

Ang paunawang ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o sa nasasaklaw ng Health Alliance Plan of Michigan. Tingnan ang mahahalagang petsa na nasa paunawang ito. Maaaring kailanganin mo na umaksiyon bago ang mga itinakdang panahon upang mapanatili ang iyong saklaw pangkalusugan o tulong nang walang gastos. May karapatan kang makuha itong impormasyon at tulong sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa (800) 422-4641.

Thông báo này chứa thông tin quan trọng về đơn đăng ký hoặc hợp đồng bảo hiểm qua chương trình Health Alliance Plan of Michigan của quý vị. Xin xem các ngày quan trọng trong trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm y tế hoặc được trợ trúp về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của quý vị mà không mất phí. Để nói chuyện với một thông dịch viên, xin gọi số (800) 422-4641.