2027 Health Alliance Plan of Michigan
Alliance Health and Life Insurance Company
Application Cover Letter

Enclosed is the application for your Health Alliance Plan of Michigan and Alliance Health and Life Insurance Company HMO, PPO or HSA health plan. In order to avoid delays in the application process, please fill out the form completely and write clearly.

Apply during open enrollment – **November 1, 2026 through January 15, 2027.** Select a plan no later than **December 15, 2026** for coverage to begin **January 1, 2027**. Enrollments received **December 16, 2026** through **January 15, 2027** will receive a **February 1, 2027** effective date.

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 that coordinates all of your healthcare needs.
- Henry Ford Health Select HMO: You'll receive care from a select range of doctors, providers and hospitals who participate in the network. The network is available to residents of Genesee, Lapeer, Oakland, Macomb, Jackson, Washtenaw and Wayne counties.
- PPO: Your care is provided by doctors who are in and out of the network, without referrals.
- High deductible health plan with health savings account: A high deductible HMO or PPO plan that is paired with an individually owned bank account to help pay for medical expenses.

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

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. Proof of the qualifying life event must also be sent to us, along with your application, by mail, email or fax within 60 days. Refer to the application to see which documents are required. Your effective date will be assigned upon review.

When finished, please print the application, sign and return with any supporting documentation to:

Mail: Health Alliance Plan
1414 E. Maple Rd.,
Troy, MI 48083
Attention: Individual Sales Team

Or you can email your application by scanning the completed document and email to **HAPIndividualSales@hap.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.**

If you have questions, please contact your agent or call us at **(855) 948-4427** or TTY: 711. We're available Monday through Friday from 8 a.m. to 5 p.m.

We look forward to working for you!

Health Alliance Plan Individual HMO is offered through Health Alliance Plan of Michigan, a state-certified health maintenance organization.

Health Alliance Plan Individual PPO plan is offered through Alliance Health and Life Insurance Company, a wholly owned subsidiary of Health Alliance Plan of Michigan.

Health Alliance Plan of Michigan and its subsidiaries do 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.
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Health Alliance Plan of Michigan
Alliance Health and Life Insurance Company
2027 Individual and Family Medical Coverage Application Form for HMO, PPO and HSA Products

Health Alliance Plan by Henry Ford Health

This application may be used for **2027 HMO and PPO individual and family coverage**. **HMO plans are offered through Health Alliance Plan of Michigan** and **PPO plans are offered through Alliance Health and Life Insurance Company (Alliance)**. Unless otherwise indicated in this application, Health Alliance Plan refers to both Health Alliance Plan and Alliance.

Health Alliance Plan of Michigan is a state-certified health maintenance organization. Alliance Health and Life Insurance Company (Alliance) is a wholly owned subsidiary of Health Alliance Plan of Michigan.

Application date: _____ **Primary applicant's legal name:** _____
(mm/dd/yyyy)

- Apply during the Open Enrollment Period Nov. 1, 2026 through Dec. 15, 2026 and your effective date of coverage will be Jan. 1, 2027.
- Apply during the Special Enrollment Period due to a qualifying life event and your healthcare coverage will be confirmed upon review.
- If your effective date of coverage is other than the 1st of the month, please contact Accounts Receivable at (888) 735-2542 to obtain the prorated premium amount due for the remainder of the current month.

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

Agent phone number: _____ Agency name: _____

Agent ID number: _____

Why are you applying? Select one.

☐ Applying for coverage during the annual Open Enrollment Period

☐ Applying for coverage during the Special Enrollment Period due to a qualifying life event

Applications for coverage during a Special Enrollment Period, must be submitted within 60 days of the life event. Documentation supporting the qualifying life event must be included with your application.

NOTE: Voluntarily canceling other health coverage or being terminated for not paying premiums are not considered loss of coverage. Neither is losing a plan that does not carry minimum essential coverage (such as a Short Term or Supplemental plan).

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

☐ Marriage (proof of prior coverage within 60 days for at least one spouse and copy of marriage certificate required)
Date of event: _____

☐ Birth of child (copy of birth certificate or hospital documentation required)
Date of event: _____

☐ Adoption or placement for adoption of child (copy of adoption certificate or placement papers required)
Date of event: _____

☐ Divorce, legal separation or death (copy of divorce decree, legal separation papers or death certificate required)
Date of event: _____

☐ Noncalendar year policy renewal (copy of renewal letter required)
Date of event: _____

☐ Permanently moving to a new area that offers new qualified health plan options (proof of prior coverage within 60 days, prior address and new or current address required)
Date of event: _____

☐ Newly gaining access to an Individual Coverage Health Reimbursement Account (ICHRA) or newly provided a Qualified Small Employer Health Reimbursement Account (QSEHRA) (copy of document from Employer offering an ICHRA/QSEHRA with start date required)
Date of event: _____

Loss of other coverage: Please check the box below that shows why you lost your health coverage.

Select only one.

☐ 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 loss of coverage required)
Date of event: _____

☐ Losing Medicaid or Children's Health Insurance Program coverage (copy of Medicaid or CHIP letter 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 upon review of your completed application.

Select Plan	Plan Marketing Name
	GOLD
☐	HAP IND HMO Gold HSA D34
☐	Henry Ford Health Select HAP IND HMO Gold HSA D34
☐	HAP IND PPO Gold HSA D34

–continued

Select Plan	Plan Marketing Name
	SILVER
☐	HAP IND HMO Silver D35
☐	Henry Ford Health Select HAP IND HMO Silver D35
☐	HAP IND PPO Silver D35
☐	HAP IND HMO Silver F55
☐	Henry Ford Health Select HAP IND HMO Silver F55
☐	HAP IND PPO Silver F55
	BRONZE
☐	HAP IND HMO Bronze H7
☐	Henry Ford Health Select HAP IND HMO Bronze H7
☐	HAP IND PPO Bronze H7
☐	HAP IND HMO Bronze HSA J86 EMB
☐	Henry Ford Health Select HAP IND HMO Bronze HSA J86 EMB
☐	HAP IND PPO Bronze HSA J86 EMB
☐	HAP IND HMO Bronze K92
☐	Henry Ford Health Select HAP IND HMO Bronze K92
☐	HAP IND PPO Bronze K92
	CATASTROPHIC
☐	HAP IND HMO Catastrophic N12
☐	Henry Ford Health Select HAP IND HMO Catastrophic N12
☐	HAP IND PPO Catastrophic N12

Health Alliance Plan HMO plans are offered through Health Alliance Plan of Michigan.
Alliance PPO plans are offered through Alliance Health and Life Insurance Company.

On Jan. 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 one Delta Dental option

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 Health Alliance Plan. In order to simplify this process, Health Alliance Plan has partnered with Delta Dental, a certified stand-alone dental carrier, who will be responsible for providing your dental benefits while Health Alliance Plan will be responsible for providing your medical benefits.

Based on the above, have you purchased pediatric dental from a certified stand-alone dental carrier?
☐ Yes ☐ No

Select option	Options
☐	**Delta Dental – pediatric and 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.

For child-only applications: When enrolling multiple children on a child-only policy, list the youngest child as the Subscriber and all others as dependents.

Please tell us about each person to be covered under this plan.
Primary applicant information

First name, MI, Last name *(Full legal 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 eligible for or enrolled in Medicare?	Race/ Ethnicity *(See options below)*
						☐ Yes ☐ No	☐ Yes ☐ No	

I am legally present in the United States and reside at least 180 days per year in an area where Health Alliance Plan is authorized to provide coverage. ☐ Yes ☐ No

Dependent information (Spouse and other family members under age 26 – or permanently disabled)

First name, MI, Last name *(Full legal 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 eligible for or enrolled in Medicare?	Race/ Ethnicity *(See options below)*
						☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	

I am legally present in the United States and reside at least 180 days per year in an area where Health Alliance Plan is authorized to provide coverage. (Applies to spouses on an application and siblings who are enrolling in a child-only plan) ☐ Yes ☐ No

*Applies to any applicant age 21 and over 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	**S**	Son (dependent)	**HD**	Permanently disabled (dependent)
H	Husband/Spouse	**D**	Daughter (dependent)		
W	Wife/Spouse				

**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. He or she 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 must be provided within 30 days of enrollment.

Race codes:

00	Unknown	**11**	Vietnamese
01	Decline to Report	**12**	Other Asian
02	White	**13**	Native Hawaiian or Other Pacific Islander
03	Black or African American	**14**	Native Hawaiian
04	American Indian or Alaska Native	**15**	Guamanian or Chamorro
05	Asian	**16**	Samoan
06	Asian Indian	**17**	Other Pacific Islander
07	Chinese	**18**	Middle Eastern or North African
08	Filipino	**19**	Another Race Not Listed Above
09	Japanese		
10	Korean		

Ethnicity codes:

00	Unknown
01	Decline to Report
20	Hispanic
21	Not Hispanic
22	Cuban
23	Mexican, Mexican American, Chicano/a
24	Puerto Rican
25	An Ethnicity Not Listed Above

Primary applicant's information (Please provide primary address P.O. boxes not accepted.)

Street address: _____ Apt. #: _____

City: _____ State: _____ ZIP code: _____ County: _____

Home phone number: _____ Cellphone: _____

Email address: _____

The primary applicant, along with their spouse and any 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? ☐ Yes ☐ No

Do you plan to keep any coverage other than the plan you are purchasing now? ☐ Yes ☐ No

If so, please complete the information below.

Subscriber name: _____ Subscriber date of birth: _____
mm/dd/yyyy

Are you a current or previous Health Alliance Plan member? ☐ Yes ☐ No

If so, what is your Health Alliance Plan ID number? _____

Name of medical coverage carrier: _____

Contract number: _____

Additional information

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

_____

_____

Billing information

Invoices will be sent to the primary applicant's address listed on this application. Coverage is not active until payment is received. Register at **hap.org/welcome** to access Bill Pay, where you can select one of these payment options:

- Make a one-time payment online 24/7 using a debit card, credit card, or Electronic funds transfer (bank account)
- Set up auto pay (automatic monthly payments using a debit card, credit card, or Electronic funds transfer (bank account)

Failure to pay the total premium by the due date will result in termination of the entire policy. You must pay your plan premiums to continue being a member of our plan.

Health Alliance Plan does not accept premium payment from third parties, except that Health Alliance Plan will accept payment of your premium from your spouse, or when appropriate, from a parent, legal guardian, agent or other person or entity that is specifically allowed by law to pay the premium on your behalf.

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 Health Alliance Plan 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.

If you selected a plan with a health savings account, or HSA, please fill out the authorization form on the following page. Otherwise, do not fill out this form.

Request for a Health Savings Account, for the following plans only:

- **HAP IND HMO Gold HSA D34**
- **Henry Ford Health Select HAP IND HMO Gold HSA D34**
- **HAP IND PPO Gold HSA D34**
- **HAP IND HMO Bronze HSA J86 EMB**
- **Henry Ford Health Select HAP IND HMO Bronze HSA J86 EMB**
- **HAP IND PPO Bronze HSA J86 EMB**

Authorization form

Health Alliance Plan recommends that you consider establishing a health savings account, or HSA, to maximize the benefits of your Health Alliance Plan high-deductible health plan. While you may open an HSA with any institution of your choice, we have arranged for you to be able to establish your high-deductible health plan and initiate the process of opening an HSA with HealthEquity*.

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

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

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

- You must not be covered by any other health insurance (other than another qualified high-deductible 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: Other health insurance generally disqualifies you from HSA eligibility but special rules apply if you've received healthcare from Veteran's Affairs or Indian Health Services.

This form is not required as part of your application for a high-deductible health plan.

☐ **Yes, I am interested in setting up a health savings account (HSA). Please have HealthEquity send me an HSA welcome kit** and initiate the process of opening an HSA for me.**

I authorize Health Alliance Plan to provide HealthEquity with information required to establish my HSA, including my name, address and Social Security number once my high-deductible health plan is activated.

I understand that:

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

☐ **I do not plan on establishing an HSA at this time.**

*The choice of an institution that offers HSAs is solely your choice and Health Alliance Plan will honor your relationship with the institution you choose. Health Alliance Plan does not provide financial services, but solely to arrange for the provision of offering healthcare services and to make payments to providers for covered services received by you under your health plan. Health Alliance Plan 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.

Health Alliance Plan is not affiliated with or related to HealthEquity. The relationship between Health Alliance Plan and HealthEquity is that of independent contractors and HealthEquity has no responsibility for the high-deductible health plan or other insurance benefits provided by Health Alliance Plan.

**A HealthEquity welcome kit will be sent once your high-deductible health plan is activated. If this health plan is not approved and activated by Health Alliance Plan, you will not receive an 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 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, residency) satisfactory to Health Alliance Plan as a condition of acceptance of this application and the issuance of coverage. Health Alliance Plan must be notified of any of these events that might change an applicant's eligibility for coverage. Notice must be received within 30 days of the event in order to provide coverage, terminate coverage and/or adjust premiums. Health Alliance Plan must be notified within 30 days of any change in residency, 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. Health Alliance Plan 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 Health Alliance Plan 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, other than a small employer, as allowed under federal law.
9. We are personally responsible for the premium payment associated with this coverage. We understand and agree that Health Alliance Plan does not accept premium payment from third parties, except from a spouse, or when appropriate, from a parent, legal guardian, agent or other person or entity that is specifically allowed by law to pay premium on our behalf.
10. 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 coverage documents.

11. If this application for coverage is accepted, coverage will be effective on the date specified by Health Alliance Plan. We understand that acceptance of premium and fees do not ensure coverage.
12. If selected, we have provided authorization for automatic withdrawal from a specified bank account or credit card for premium payment and administrative fees.
13. Premiums already paid will be refunded if coverage is not issued.
14. 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.
15. 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 Health Alliance Plan may offset any premiums to be returned to us by an amount not to exceed incurred claims expense.
16. Each applicant waives his or her right to receive a hard copy of their coverage documents and this application, but understand that he or 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 Health Alliance Plan may not raise issues concerning the accuracy of the statement contained in this application if he or she is not given a hard copy of this application.
17. We understand and agree that required legal notices and communication (including coverage documents, renewal notifications and other documents concerning coverage or rights under the contract or policy) may be delivered electronically to the email address designated and not through U.S. 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 canceled at any time without charge. Cancellation of this consent can be exercised and requests for paper copies can be sent to: Customer Service at 1414 E. Maple Rd., Troy, MI 48083. Updates to the email address can be sent to Customer Service. In order to obtain electronic documents from Health Alliance Plan's website, we recommend the use of commercially available web browsers. Health Alliance Plan's website contains documents in PDF format that may require Adobe Reader or other commercially available software to access.
18. Any applicants that do not meet the definition of spouse will be split into two contracts or policies. Dependents will remain with the primary applicant unless otherwise directed.
19. We attest that if not purchasing pediatric dental benefits from Delta Dental (through Health Alliance Plan), we will purchase (or have purchased) benefits from a certified, stand-alone dental carrier. Health Alliance Plan 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.
20. We can confirm that no one applying for medical coverage on this application is incarcerated other than incarceration while awaiting disposition of charges.
21. We understand that any person currently eligible for or enrolled in Medicare or any person currently incarcerated will not be covered under this contract/policy.
22. We understand that if accepted, the primary applicant will be set up as the subscriber. In the future, should the subscriber request to terminate their coverage, the spouse and/or dependent(s) can request to retain coverage under the existing contract or policy. Health Alliance Plan must be notified of this request at the time the subscriber's coverage is cancelled. We also understand that all agreements, signatures, and obligations agreed to in this application are binding and transfer to the subscriber listed on the adjusted contract or policy.
23. If coverage is issued, we understand and agree that the subscriber has the authority to cancel coverage and make coverage changes under the contract/policy with regards to adult dependents. Health Alliance Plan will notify adult dependents of any changes made.
24. If coverage is issued, we understand and agree that any adult dependent covered under the contract/policy has the authority to cancel their own coverage. Health Alliance Plan will notify the subscriber of any changes made by an adult dependent.

25. If coverage is issued, we understand and agree that the licensed agent of record on the contract/policy can request the following changes on behalf of the individuals named in this application if these changes are requested in writing or via email.
    a. Change the plan selected on this application to another plan offered by Health Alliance Plan.
    b. Cancel coverage under the plan selected on this application for one or more of the individuals covered under the contract/policy.
    c. Add or remove adult and/or pediatric dental coverage for all individuals covered under the contract/policy.
    d. Health Alliance Plan will notify the subscriber and all applicable adult dependents covered under the contract/policy of the requested changes.
26. I attest that the primary applicant and his or her spouse-dependent covered under a policy issued pursuant to this application are each United States citizens or otherwise legally present in the United States, and, for at least 180 days per year, each shall reside in the State of Michigan in an area in which Health Alliance Plan is authorized to provide coverage issued pursuant to this application. I understand that if the primary applicant or his or her spouse-dependent covered under a policy issued pursuant to this application moves out of a Health Alliance Plan service area, Health Alliance Plan will terminate coverage.
27. To provide transparency, we've outlined the commission program offered to producers for selling Health Alliance Plan products.
    a. Individual policies are charged the same premium, regardless of whether they use an agent or enroll directly with Health Alliance Plan.
    b. An agent's commission ranges between 1% and 6% of premiums (depending on the transaction at issue and the terms of the underlying contracts).

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

In order for your paper application to be processed, the Health Alliance Plan Sales team will enter the fully completed and signed paper application into our system. We will electronically sign the application, 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 U.S. mail, fax or email to Health Alliance Plan, Attention: Health Alliance Plan Customer Service, 1414 E. Maple Rd., Troy, MI 48083.

Authorization

I authorize any physician, medical or healthcare practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, third-party administrator, pharmacy, pharmacy benefit manager, pharmacy related facility, insurance company, HMO or reinsuring company, the Medical Information Bureau, Inc., agent, employer or a consumer reporting agency to share any and all 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, nonpublic personal health information and any other nonmedical information to share any and all such information with Health Alliance Plan, its reinsurer, its legal representatives and its affiliates in order to process my application for coverage.

This authorization will not be used by Health Alliance Plan to conduct a medical underwriting function for the purpose of establishing eligibility or premiums associated with the coverage being applied for. Health Alliance Plan will use and disclose your information only in accordance with its Notice of Privacy Practice which is available at hap.org or by contacting us at **(800) 422-4641 (TTY: 711)**.

Health Alliance Plan, 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 Health Alliance Plan 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, Health Alliance Plan 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 Health Alliance Plan Customer Service, 1414 E. Maple Rd., Troy, MI 48083 or email to **Yourhap@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 Health Alliance Plan Customer Service.

Disclosure

Health Alliance Plan of Michigan and its subsidiaries do 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
1414 E. Maple Rd., Troy, MI 48083
Attention: Individual Sales Team

Or scan the completed application and email to:

HAPIndividualSales@hap.org

If you are an agent completing this application on behalf of the primary applicant, please read the following attestation, check the box to indicate your agreement, sign and date below.

Agent attestation

☐ As a licensed and qualified agent authorized to do business with Health Alliance Plan, I attest to the following:

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

Agent Name: _____

Date: _____

If you are the parent or legal guardian completing this application on behalf of a minor child or children, 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, copays, 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 Health Alliance Plan.
3. I shall notify Health Alliance Plan if my authority to act on their behalf were to change.
4. Health Alliance Plan is entitled to rely upon this attestation.
5. I shall be legally responsible for errors and omissions in the application that result from my own negligence or intentional misrepresentation.

Parent/Legal guardian's date of birth: _____
mm/dd/yyyy

Last four digits of Parent/Legal guardian's social security number:_____

Any person who knowingly submits an application containing a false, incomplete or deceptive statement with intent to defraud may be subject to criminal and civil penalties.

A parent/guardian will need to sign the application on behalf of the youngest child and a signature will be required for each dependent age 18 and over.

Primary applicant or legal representative signature: _____ Date: _____
mm/dd/yyyy

Primary applicant or legal representative printed name: _____ Date: _____
mm/dd/yyyy

Relationship of legal representative: _____ Date: _____
mm/dd/yyyy

Spouse signature: _____ Date: _____
(If applying for coverage) mm/dd/yyyy

Child signature: _____ Date: _____
(If applying and 18 years of age or older) mm/dd/yyyy

Child signature: _____ Date: _____
(If applying and 18 years of age or older) mm/dd/yyyy

Child signature: _____ Date: _____
(If applying and 18 years of age or older) mm/dd/yyyy

Child signature: _____ Date: _____
(If applying and 18 years of age or older) mm/dd/yyyy

Health Alliance Plan®
by Henry Ford Health

Nondiscrimination Notice

Health Alliance Plan of Michigan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Health Alliance Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Health Alliance Plan 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 Health Alliance Plan's customer service:
General - (800) 422-4641 (TTY: 711) **Medicare -** (800) 801-1770 (TTY: 711)
Hours are 8 a.m. to 8 p.m., Seven Days a Week (Oct. 1 – March 31) and
8 a.m. to 8 p.m., Monday through Friday (April 1 - Sept. 30)

If you believe that Health Alliance Plan 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 Health Alliance Plan's Appeal & Grievance team. Use the information below:

- **Mail:** 1414 E. Maple Rd., Troy, Michigan 48083
- **Phone:** **General -** (800) 422-4641 (TTY: 711)
  Medicare - (800) 801-1770 (TTY: 711)
- **Fax:** (313) 664-5866

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/

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Notice of Availability of Language Assistance Services and Auxiliary Aids

ENGLISH:
ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-801-1770 (TTY:711) or speak to your provider.

SPANISH:
ATENCIÓN: Si habla español, los servicios de asistencia con el idioma están disponibles para usted sin cargo. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-801-1770 (TTY: 711) o hable con su proveedor.

ARABIC:
انتباه: إذا كنت تتحدَّث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تتوفَّر أيضًا المساعدات وخدمات المساعدة مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم الآتي: 1-800-801-1770 (الهاتف النصي: 711) أو تحدَّث إلى مقدِّم الخدمة.

CHINESE TRADITIONAL:
請注意：如果您說中文，您可以免費獲得語言協助服務。另免費提供適當的輔助工具和服務並以無障礙格式提供資訊。請致電 1-800-801-1770 (TTY: 711)或聯絡您的提供者。

CHINESE SIMPLIFIED:
请注意：如果您说中文，您可以免费获得语言协助服务。另免费提供适当的辅助工具和服务并以无障碍格式提供信息。请致电 1-800-801-1770 (TTY: 711)或联系您的提供者。

ARAMAIC:
ܐܝܟ ܡܐ ܕܐܢ ܐܢܬ ܡܡܠܠ ܐܪܡܝܐ

Health Alliance Plan®
by Henry Ford Health

BENGALI:
মনোযোগ: আপনি যদি বাংলা ভাষায় কথা বলেন তবে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সাহায্য এবং পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। 1-800-801-1770 (TTY:711) নম্বরে কল করুন বা আপনার প্রদানকারীর সাথে কথা বলুন।

POLISH:
UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Odpowiednie materiały pomocnicze i usługi zapewniające informacje w dostosowanych formatach są również dostępne bezpłatnie. Należy zadzwonić pod numer 1-800-801-1770 (TTY: 711) lub porozmawiać z lekarzem prowadzącym.

GERMAN:
HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie unter 1-800-801-1770 (TTY:711) an oder sprechen Sie mit Ihrem Dienstleister.

ITALIAN:
ATTENZIONE: Se parli italiano, sono a tua disposizione servizi gratuiti di assistenza linguistica. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-800-801-1770 (TTY:711) o parla con il tuo fornitore.

JAPANESE:
ご案内: 日本語を話される方の場合、無料で言語支援サービスをご利用いただけます。また、情報をわかりやすい形式でご提供するための補助機器やサービスも無料でご利用いただけます。詳しくは、1-800-801-1770（TTY: 711）までお電話いただくか、担当の医療提供者にご相談ください。

RUSSIAN:
ВНИМАНИЕ: Если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также можно получить бесплатно. Позвоните по номеру 1-800-801-1770 (TTY:711) или обратитесь к своему врачу.

SERBIAN:
PAŽNJA: Ako govorite srpski, dostupne su vam besplatne usluge jezičke pomoći. Odgovarajuća pomoćna sredstva i usluge za pružanje informacija u pristupačnim formatima takođe su dostupni besplatno. Pozovite 1-800-801-1770 (TTY:711) ili se obratite pružaocu usluga.

TAGALOG:
PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Makukuha rin nang libre ang mga naaangkop na pantulong na suporta at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-801-1770 (TTY: 711) o makipag-usap sa iyong provider.