2025 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, 2024 through January 15, 2025** – and your effective date of coverage will be January 1, 2025 or February 1, 2025.

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 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.
- 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/plans**. 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: HAP
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) WITH-HAP** (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!

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

HAP's Personal Alliance PPO plan is offered through Alliance Health and Life Insurance Company, a wholly owned subsidiary of HAP.

HAP 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.
 HAP484374 – 8/2024

Health Alliance Plan of Michigan
Alliance Health and Life Insurance Company
2025 Individual and Family Medical Coverage
Application Form for HMO, PPO and HSA Products

This application may be used for 2025 HMO and PPO individual and family coverage. HMO plans are offered through Health Alliance Plan of Michigan (HAP) and PPO plans are offered through Alliance Health and Life Insurance Company (Alliance). Unless otherwise indicated in this application, HAP refers to both HAP and Alliance.

Health Alliance Plan of Michigan (HAP) 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, 2024 through Jan 15, 2025 and your effective date of coverage will be Jan. 1, 2025 or Feb. 1, 2025
- Apply during the Special Enrollment Period due to a qualifying life event and your health care 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 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 D3
☐	HAP IND HMO Gold HSA D3 Henry Ford Choice
☐	HAP IND HMO Gold HSA D3 Genesys Choice
☐	HAP IND PPO Gold HSA D3
	SILVER
☐	HAP IND HMO Silver D35

☐	HAP IND HMO Silver D35 Henry Ford Choice
☐	HAP IND HMO Silver D35 Genesys Choice
☐	HAP IND PPO Silver D35
☐	HAP IND HMO Silver F55
☐	HAP IND HMO Silver F55 Henry Ford Choice
☐	HAP IND HMO Silver F55 Genesys Choice
☐	HAP IND PPO Silver F55
	BRONZE
☐	HAP IND HMO Bronze H7
☐	HAP IND HMO Bronze H7 Henry Ford Choice
☐	HAP IND HMO Bronze H7 Genesys Choice
☐	HAP IND PPO Bronze H7
☐	HAP IND HMO Bronze HSA H705 EMB
☐	HAP IND HMO Bronze HSA H705 EMB Henry Ford Choice
☐	HAP IND HMO Bronze HSA H705 EMB Genesys Choice
☐	HAP IND PPO Bronze HSA H705 EMB
☐	HAP IND HMO Bronze K92
☐	HAP IND HMO Bronze K92 Henry Ford Choice
☐	HAP IND HMO Bronze K92 Genesys Choice
☐	HAP IND PPO Bronze K92
	CATASTROPHIC
☐	HAP IND HMO Catastrophic K92
☐	HAP IND HMO Catastrophic K92 Henry Ford Choice
☐	HAP IND HMO Catastrophic K92 Genesys Choice
☐	HAP IND PPO Catastrophic K92

HAP HMO plans are offered through Health Alliance Plan of Michigan (HAP)
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 HAP. In order to simplify this process, HAP has partnered with Delta Dental, a certified stand-alone dental carrier, who will be responsible for providing your dental benefits while HAP will be responsible for providing your medical benefits.

Based on the above, have you purchased pediatric dental from a 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)
						☐Y ☐N	☐Y ☐N	

I am legally present in the United States and reside at least 180 days per year in an area where HAP 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)
						☐Y ☐N	☐Y ☐N	
						☐Y ☐N	☐Y ☐N	
						☐Y ☐N	☐Y ☐N	
						☐Y ☐N	☐Y ☐N	
						☐Y ☐N	☐Y ☐N	

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

*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)
W – Wife/Spouse
D - Daughter (dependent)
H – Husband/Spouse
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. 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 options:

* American Indian or Alaska Native
* Asian
* Asian Indian
* Black or African American
* Chinese
* Filipino
* Guamanian or Chamorro
* Japanese
* Korean
* Middle Eastern or North African
* Native Hawaiian
* Native Hawaiian or Other Pacific Islander
* Other Asian
* Other Pacific Islander
* Samoan
* Vietnamese
* White
*Other race not listed
* Unknown
* I choose not to answer

If Hispanic/Latino Ethnicity choose an option below:

* Cuban
* Hispanic
* Not Hispanic
* Mexican, Mexican American, Chicano/a
* Unknown
* I choose not to answer
* Puerto Rican
* Other ethnicity not listed

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? ☐ 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 name: _____ Subscriber 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

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.

HAP does not accept premium payment from third parties, except that HAP 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 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.

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 HAP IND HMO Gold HSA D3, HAP IND PPO Gold HSA D3, HAP IND HMO Bronze HSA H705 EMB and HAP IND PPO Bronze HSA H705 EMB)

Authorization form

HAP recommends that you consider establishing a health savings account, or HSA, to maximize the benefits of your HAP 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. HAP 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 health care 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 HAP 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, HAP will not provide HealthEquity 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 an HSA.
- I may revoke this authorization at any time before a HealthEquity 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 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 HAP will honor your relationship with the institution you choose. HAP does not provide financial services, but solely to arrange for the provision of offering 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 HealthEquity. The relationship between HAP and HealthEquity is that of independent contractors and HealthEquity has no responsibility for the high deductible health plan or other insurance benefits provided by HAP.

**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 HAP, 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 HAP as a condition of acceptance of this application and the issuance of coverage. HAP 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. HAP 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. 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, 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 HAP 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 HAP. 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 HAP 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 HAP 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 HAP's website, we recommend the use of commercially available web browsers. HAP'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 HAP), we will purchase (or have purchased) benefits from a 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.
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. HAP 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. HAP 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. HAP 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 HAP.
    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. HAP 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 HAP 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 HAP service area, HAP will terminate coverage.
27. To provide transparency, we've outlined the commission program offered to producers for selling HAP products.
    a. Individual policies are charged the same premium, regardless of whether they use an agent or enroll directly with HAP.
    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 HAP 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 HAP, Attention: HAP Customer Service, 1414 E. Maple Rd., Troy, MI 48083.

Authorization

I 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 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 HAP, its reinsurer, its legal representatives and its affiliates in order to process my application for coverage.
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 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.

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 HAP 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 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 HAP Customer Service.

Disclosure

HAP 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:
HAP
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 HAP, 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 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 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 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.
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

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(If applying and 18 years of age or older) mm/dd/yyyy

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 does not exclude people or treat them differently because 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:

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 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 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/**

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-801-1770 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete gratis para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para hablar con un intérprete, llame al 1-800-801-1770 (TTY: 711). Alguien que hable español lo podrá ayudar. Este es un servicio gratis.

Chinese Mandarin: 我们提供免费的口译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要这项口译服务，请致电 1-800-801-1770 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存在疑問，為此我們提供免費的傳譯服務。如需傳譯服務，請致電 1-800-801-1770 (TTY: 711)。我們講中文的人員將樂意為您提供協助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o gamutan. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-801-1770 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay isang libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime d’assurance maladie ou d'assurance médicaments. Pour accéder au service d'interprétation, vous pouvez nous appeler au 1-800-801-1770 (TTY : 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương trình sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên, xin gọi 1-800-801-1770

(TTY: 711), sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihnen gerne Fragen zu unseren Gesundheits- und Arzneimittelprogrammen. Unsere Dolmetscher erreichen Sie unter 1-800-801-1770 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-801-1770 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или плана предоставления медикаментов, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-801-1770 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-801-1770 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-801-1770 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिन्दी भाषा बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-801-1770 (TTY: 711). Un nostro incaricato che parla italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que você tenha quanto ao nosso plano de saúde ou de medicação. Para obter um intérprete, entre

em contato conosco pelo número 1-800-801-1770 (TTY: 711). Você encontrará alguém que fale o idioma Português para ajudá-lo. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèpretasyon gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa plan medikaman nou an. Pou w jwenn yon entèprèt, jis rele nou nan 1-800-801-1770 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza, który pomoże w uzyskaniu odpowiedzi na temat ubezpieczenia zdrowotnego lub refundacji leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-801-1770 (TTY: 711). Usługa jest bezpłatna.

Japanese: 当社の医療保険や医薬品に関する質問にお答えするため、無料の通訳サービスをご用意しております。通訳サービスをご希望の方は、1-800-801-1770 (TTY: 711)までお電話ください。日本語を話せるスタッフがご対応いたします。こちらは無料のサービスです。