HAP HMO Enrollment Application

To be filled out by employer:			
Group ID:	Sub-Group ID:	Class ID:	Effective Date of Coverage:

Important: List family members you are covering. Legal first name and middle initial only. Last name if different from yours.

Note: Orange shaded areas are required.

To be filled out by applicant:							
Enrolling for: ❑ HMO ❑ POS							
Last Name: Legal First Name: Middle Initial:			Primary Phone:	Birth Date:	Male ❑ Female ❑	Tobacco Use (over last six months)** Yes No	Social Security Number:
Address: Apt.: City: State: Zip: County:							Email:
Name of Employer:			Date of Hire (required):	Location Code:			Date of Retirement (If Applicable):
Personal Care Physician:				PCP Code/NPI:			Network:

Name and Middle Initial of Dependents:	Social Security Number:	Birth Date:*	Sex:	Tobacco Use (over last six months):**	Relationship (See Codes Below):	Personal Care Physician:	PCP Code:
				Yes No			
				Yes No			
				Yes No			
				Yes No			
				Yes No			

*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.

**Applies to any applicant over age 18 who uses tobacco products regularly (four or more times per week), excluding those for religious use.

Relationship Codes:

M–Subscriber	H–Husband/Spouse	D–Daughter (Dependent)	OP–Other Partner (University Clients Only)	SD–Sponsored Dependent (without Medicare)
W–Wife/Spouse	S–Son (Dependent)	DP–(Domestic Partner)	HD–Permanently Disabled (Dependent)	SR–Senior Rider (with Medicare)

Does anyone listed above have other health care coverage? If yes, complete the following:

❑ Self ❑ Spouse ❑ Dependent

Type of coverage ❑ BCBS ❑ Other _____

Medicare Number_____

Effective Date for Part A _____

Effective Date for Part B _____

Medicaid Number_____

Have you or any of your dependents previously been a HAP or Alliance member? Yes No

Name_____

Former Number _____

Name/#_____

Name/#_____

Name/#_____

Are you to provide medical coverage for a child(ren) listed above according to a qualified medical child support order (QMSCO)? Yes No

If yes, please attach document.

Does a qualified medical child support order (QMSCO) exist for any dependent child(ren) listed on this application? Yes No

If yes, please attach document.

MUST be signed below by person applying for coverage.

I am applying for the group health benefits that I am eligible for with my employer. All of the information I have given in this application is true and complete.

I know that if I give any false or misleading information on purpose my enrollment may be rejected or my enrollment may be terminated back to the date of the application. I know that if I leave out important information on this form my enrollment may be rejected or my enrollment may be terminated back to the date of the application. I know that I must also give true and complete information for my dependents (such as children, spouse or partner) or their enrollment may be rejected or terminated back to the date of the application.

Applicant Signature

Date: MM/DD/YY

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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 বিজ্ঞপ্তিতে Health Alliance Plan of Michigan মাধ্যমে আপনার আবেদন বা কভারেজে সম্বন্ধে গুরুত্বপূর্ণ তথ্য আছে। এই বিজ্ঞপ্তিতে গুরুত্বপূর্ণ তারিখগুলি খোঁজ করুন। আপনার হেলথ কভারেজে ঠিকঠাক রাখতে বা খরচ সম্পর্কিত সহায়তার জন্য আপনাকে নির্দিষ্ট সময়সীমাগুলির মধ্যে অ্যাক্সন নিতে হতে পারে। বিনা খরচে আপনার নিজস্ব ভাষাতে সহায়তা পাবার এবং তথ্য জানবার অধিকার আপনার আছে। একজন দো·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.

ܗܳ, ܫܒܝܩܬܳܐ ܕܝܫܘܥܳܐ ܡܶܢ ܫܘܪܳܝܳܐ ܕܐܶܢܬܳܢܳܝܳܐ ܕܐܶܢܬܳܪܬܳܐ ܕܚܘܠܳܡܳܐ ܕܐܶܢܬܳܪܬܳܐ ܕܫܘܬܳܦܘܬܳܐ
ܕ Health Alliance Plan of Michigan. ܠܶܚܳܝ ܬܳܠܳܐ ܫܒܥܳܝܶܢ ܕܐܶܢܬܳܢܳܝܳܐ ܕܥܒܝܳܐ ܡܶܢ ܫܒܝܒܳܐ ܟܳܕ ܕܗ, ܫܒܝܩܬܳܐ. ܫܠܚܶܝ ܕܫܳܘܬܳܐ ܕܐܶܢܬܳܢܳܝܳܐ
ܕܥܡܠܒܳܐ ܒܕܚܬܳܐ ܩܳܒܥܶܝܠܳܝ ܫܶܝ ܩܕܶܡ ܫܘܳܬܳܐ ܕܒܕܚܬܳܐ ܕܐܶܢܬܳܢܳܝܳܐ ܕܐܶܢܬܳܪܬܳܐ، ܗܳܕܳܐ ܕܪܚܶܝ ܒܳܐ ܕܒܚܒܳܐ ܕܥܡܠܒܳܐ ܡܶܢ ܬܳܠܳܐ ܕܫܘܬܳܦܘܬܳܐ ܕܥܡܠܒܳܐ
ܫܒܝܳܬܳܐ ܚܕܳܚܬܳܐ ܕܪܚܶܝ ܐܶܝܟܳܐ. ܐܒܠܠܳܐܝܳܐ ܫܡܝܳܬܳܐ ܕܥܡܠܒܳܐ ܕܫܒܝܳܬܳܐ ܕܚܘܠܳܡܳܐ ܕܐܶܢܬܳܢܳܝܳܐ ܕܐܶܢܬܳܪܬܳܐ ܕܫܘܬܳܦܘܬܳܐ ܕܥܡܠܒܳܐ ܕܫܒܝܳܬܳܐ
ܚܕܳܐ ܟܬܒܬܳܐ، ܡܢܒܚܳ ܟܠܕܶܬܳܐ ܕܝܬܶܢܬܳܐ ܕܝܠܒܚܳ 422-4641 (800).

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.