



Last Name	Legal First and Middle Initial	Social Security No.	Phone ()	Birth Date	Male <input type="checkbox"/>	Group No. & Suffix
Address		Apt.	City	State	Zip	County E-mail
Name of Employer		Date of Hire	Department Code		Effective Date	
Medical Center/Physician Network Code		Personal Care Physician	PCP Code		HAP #	

IMPORTANT - List Family Members you are covering. Legal First Name and Middle Initial Only • Last Name if different from yours NOTE: GREY SHADED AREAS FOR INTERNAL USE ONLY

NAME AND INITIAL	SOCIAL SECURITY NO.	BIRTH DATE	SEX	RELATIONSHIP	MEDICAL CENTER OR PHYSICIAN NETWORK CODE	PERSONAL CARE PHYSICIAN	PCP CODE	HAP NUMBER
SPOUSE								
DEPENDENTS								

DUPLICATE COVERAGE

Are you or your spouse or dependents covered under any other group medical, pharmacy, or vision plan (including your spouse's employer), or Medicare? Check One Yes No

Are any of your dependents included in a divorce decree with health care coverage? Check One Yes No

Court Ordered Parent's Name and Social Security Number _____ (Attach a copy of the order if not already on file).

If you answered yes to either of the above questions, please fill in the information below. If applicable, please note which dependent is covered under the court order above.

	NAME OF EMPLOYER (INCLUDE ADDRESS AND PHONE)	NAME OF INSURANCE CARRIER (INCLUDE ADDRESS AND PHONE)	POLICY NUMBER(S)	PERSON(S) COVERED
MEDICAL				
PHARMACY				
VISION				

MEDICARE: Complete the following section for yourself and each family member covered under Medicare.

NAME	MEDICARE CLAIM NUMBER	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE

HAVE YOU OR ANY OF YOUR DEPENDENTS PREVIOUSLY BEEN A HAP MEMBER?

YES NO

FORMER NAME _____

FORMER HAP NO. _____

SPOUSE'S MAIDEN NAME _____

RELATIONSHIP CODES

SP - SPOUSE

DC - DEPENDENT CHILD

PS - PRINCIPAL SUPPORT

YA - YOUNG ADULT (19-25 YRS.)

SD - SPONSORED DEPENDENT (NO MEDICARE)

HD - HANDICAPPED DEPENDENT CHILD

SR - SENIOR RIDER (25 YEARS OR OLDER WITH MEDICARE)

DP - DOMESTIC PARTNER

I HAVE READ AND AGREE TO THE TERMS ON THE REVERSE SIDE

SIGN HERE

DATE

Processor

Date



Enrollment Application for HMO Product

Please select a Medical Center or Physician Network (below) for yourself and each member of your family and list the appropriate code on the Application on the other side of this card. A personal care physician must be chosen for each new member before application is complete.

Medical Centers and Codes:

A00 — DMC Physician Network	F22 — HFMC - Grosse Pointe Pierson	F38 — HFMC - Southfield	P12 — PMC - Adult Personal Care Physicians Group II
F15 — HFMC - Ann Arbor	F29 — HFMC - Hamtramck	F11 — HFMC - Southland, Taylor	P02 — PMC - Deighton Family Practice Center, Southfield
F16 — HFMC - Canton	F39 — HFMC - Harbortown	F04 — HFMC - Sterling Heights	P15 — PMC - Farmington Hills
F01 — HFMC - Detroit	F06 — HFMC - Lakeside, Sterling Heights	F25 — HFMC - Taylor	P08 — PMC - Livonia
F34 — HFMC - Detroit East	F35 — HFMC - Livonia	F14 — HFMC - Troy	P14 — PMC - Pediatric Personal Care Physicians Group II
F33 — HFMC - Detroit Northwest	F40 — HFMC - New Center One	F12 — HFMC - Warren	P03 — PMC - Providence Park, Novi
F21 — HFMC - East Jefferson - Family Practice	F36 — HFMC - Novi	F02 — HFMC - West Bloomfield	P04 — PMC - South Lyon
F03 — HFMC - Fairlane, Dearborn	F05 — HFMC - Plymouth	F24 — HFMC - Woodhaven	
	F08 — HFMC - Royal Oak	P11 — PMC - Adult Personal Care Physicians Group I	

DMC = Detroit Medical Center HFMC = Henry Ford Medical Center PMC = Providence Medical Center

Physician Networks and Codes:

A11 — Access IPA	SU1 — McLaren Health Care Corporation, Flint	SK2 — St. Clair IPA	J06 — St. John Macomb - St. Clair Primary Physician Group
SX1 — Botsford General Hospital Network, Farmington Hills	SU2 — McLaren Health Care Corporation, Lapeer	SK1 — St. Clair Other Available Specialits	J05 — St. John NorthEast Community Hospital, Detroit
SC1 — Crittenton Hospital Network, Rochester	SQ1 — Monroe Physician Network	St. John HealthPartners PHO Network	J07 — St. John North Shores Hospital, Harrison Twp.
SE1 — Eastern Shores Network	MC1 — Mt. Clemens General Network, Mt. Clemens (PHO)	J01 — St. John Hospital & Medical Center, Detroit	AL1 — St. Joseph Mercy - Ann Arbor Network
SN1 — Farmington Family Physicians	NO1 — North Oakland Medical Centers (NOPHO - North Oakland Physician Hospital Organization)	J02 — St. John Oakland Hospital, Madison Heights	SB1 — St. Joseph Mercy Hospital Oakland Network (Oakland Physicians Network Services)
SV1 — Genesys PHO	OH1 — Oakwood Healthcare System - United Oakwood Providers	J03 — St. John Macomb Hospital, Warren	SL1 — Wyandotte IPA
SI2 — Henry Ford Bi-County Hospital Network	AC1 — Premier Physician Network (Beaumont Medical Staff Physicians)	J04 — St. John Detroit Riverview Hospital, Detroit	
SD1 — Independent Physicians of Macomb County, Clinton Township and Mt. Clemens			



HMO ENROLLMENT APPLICATION CONTRACT

I apply on behalf of myself and eligible family members, as listed, for enrollment in and for the health services provided to members of Health Alliance Plan, which is now available through my employer's insurance program. I hereby revoke all previous enrollment applications executed by me for hospital and medical expense coverage as made available by my employer.

I may enroll my unmarried children legally residing with me who are either my own, or legally adopted, or those of my spouse by a previous marriage as defined below.

I may list dependent children to age 19. Such children can be covered through December 31 of the year in which they turn 19.

If my group offers the Young Adult Rider, I may list unmarried dependent children between age 19 and 25. Such children are covered to December 31 of the year in which they turn 25, as long as they reside with me, or, if residing elsewhere, are full-time students.

I understand that unmarried children, disabled before age 19 are considered to be dependent children and covered to any age. Such children must be incapable of self-sustaining employment by reason of mental retardation or physical handicap; and must have previous coverage. I understand that I must provide medical documentation verifying the disability.

I understand that I and my dependents will not be eligible for hospital admissions, doctor's services and other covered services until the effective date of my membership as determined by Health Alliance Plan and my employer.

I authorize persons rendering medical or hospital care and related service (including hospitals and medical groups contracting with Health Alliance Plan) to provide records and other information concerning such care or services to Health Alliance Plan.

Whenever the full subscription rate is not paid by my employer, I authorize my employer to periodically deduct in advance from my wages and to remit to Health Alliance Plan, the amount necessary to pay the periodic rate.

The subscriber may cancel this application within 72 hours after signing by sending written notice to Health Alliance Plan or their employer.