ALLIANT Health Plans

GROUP ADMINISTRATION FORM

Mail To:
Alliant Health Plans
401 S. Wall St., Ste 201
Calhoun, GA 30701
800-664-8480, ext. 2506
706-629-3593 (Fax)

Group Name: ______________________________

Group Number: ______________________________

Email: ______________________________

Date: ______________________________

Prepared by: ______________________________

Phone Number: ______________________________

EMPLOYEE					DEPENDENT				
(Employee name and social security number must always be entered)									*****Changes/Term Reason/Remarks (see below)**
Employee Name	Employee SSN	*Transaction Code	Effective/ Term Date	**Cobra Qualifying Event	Dependent Name	*Transaction Code	Effective/ Term Date	**Cobra Qualifying Event	

* **Transaction Code Key:** N = New Enrollment; T = Termination (date should be last day of coverage); C = change (describe change in remarks section)

All New Enrollments: Submit the original, signed, fully completed enrollment form and attach it to this form. Newborns **MUST** be enrolled within 31 days of birth to be covered.

Note: The addition of dependents due to a "Qualifying Event" such as marriage, divorce, or loss a coverage require supporting documents such as marriage certificate, divorce decree, loss of employment status. Please provide the other employer's name and phone number.

** **Cobra Qualifying Event Key:** 1= Termination of employment; 2 = Reduction of hours; 3 = Medicare; 4 = Divorce; 5 = Overage Dependent Child; 6 = Employee still working but chooses to cancel coverage

Note: If Alliant does not administer COBRA, a COBRA election letter will not be mailed

*****Changes:** Please provide the new information for the following types of changes: PCP, Address, Phone, Other Coverage, *College Status, Other
*A change to College Status requires verification of enrollment from the Registrar's office of the institution

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