ALIERA Healthcare

Member Registration Form
Email to: application@alierahealthcare.com
HealthPass USA

Member

Last Name	First Name	MI	Language	○ Male ○ Female	Date of Birth mm/dd/yyyy
Street Address (No P.O. Box)	City		State	Zip	
Email	Authorized to email? ○ Yes ○ No		SSN#		
Phone ( ) - ○ Cell ○ Home ○ Work	Phone 2 ( ) - ○ Cell ○ Home ○ Work				

Membership Plans

**Note: Enrollment must be completed before the 15th of the month before the effective date AND first month's premiums received. Coverage cannot be back-dated*

Please select your Plan* (For Plan choices and complete Plan descriptions, please visit www.alierahealthcare.com or www.healthpassusa.com)

○ **TeleHealthPass/First Call** ○ **Med-Select** ○ **Med-Select +** ○ **HealthPass Value Plan** ○ **HealthPass PLUS** ○ **HealthPass PLUS PPO**

○ **HealthPass Premium** ○ **HealthPass Premium PPO** ○ **Aliera Prime – Core 4** ○ **Aliera Prime – Bronze** ○ **Aliera Prime – Silver** ○ **Aliera Prime – Gold**

○ **Aliera Prime - Platinum** _____

○ Add on: **Wholesale Pharmacy Plan** – ***powered by Rx Valet*** ○ Add on: **Aliera VB** ○ Add on: **Aliera VB +**

Type of Plan: ○ **New** ○ **Modified** ○ **Reinstatement (HPCID#):** _____ Desired Effective Date mm/dd/yyyy

Employer Group Sponsorship

Fill out this section if you are an individual enrolling in Aliera Plans as the eligible employee under an Employer-sponsored group.

Name of Employer HPUSA CI#

Payroll Cycle: ○ **Bi-Weekly** ○ **Weekly** ○ **Bi-Monthly** ○ **Other**

The contribution can be a percentage or a fixed dollar amount. No minimum required.

Company contribution for employee:	**Company contribution for dependents:**
$ **or** % of the membership	$ **or** % of membership

Your eligible dependents can enroll in Aliera Plans if you have purchased individual/family coverage or if your employer offers coverage for employee dependents.

Dependent Information –*If dependent has a different mailing address, please provide name and address on a separate piece of paper and attach hereto.

1	Relationship to employee:			**SSN:**	
Last Name	First Name	MI		○ Male ○ Female	Date of Birth mm/dd/yyyy
2	Relationship to employee:			**SSN:**	
Last Name	First Name	MI		○ Male ○ Female	Date of Birth mm/dd/yyyy
3	Relationship to employee:			**SSN:**	
Last Name	First Name	MI		○ Male ○ Female	Date of Birth mm/dd/yyyy
4	Relationship to employee:			**SSN:**	
Last Name	First Name	MI		○ Male ○ Female	Date of Birth mm/dd/yyyy

Authorization — Member Agreement and Disclosure Statement

Terms

• I acknowledge and understand that I am voluntarily becoming an Aliera Healthcare, Inc./HealthPass USA LLC ("AHI/HP USA") member and that this agreement is non-transferable.

• I understand I will receive an electronic copy of the Explanation of Coverage Guide and I will be given the opportunity to ask questions and receive answers regarding its content.

• I acknowledge and understand that this agreement does not provide comprehensive health insurance coverage nor is it a contract of insurance and that it provides only the health care services specifically described in the AHI/HP USA Explanation of Coverage Guide.

• I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside of AHI/HP USA network including but not limited to emergency room, hospital and specialty services and that AHI/HP USA will not bill insurance carriers for any services provided by AHI/HP USA network.

• I acknowledge and understand that AHI/HP USA providers must maintain a record of my health information and must protect the privacy of my health information as per the terms of the Notice of Privacy Practices. I understand and acknowledge that this policy is available for my review at any time at AlieraHealthCare.com/privacy or HealthPassUSA.com/privacy or upon request.

• I acknowledge and agree to pay my monthly membership fee on or before its due date. In the event that I am unable to pay my fee(s) on time, I understand that I will be charged a $25 late fee, lose eligibility, and risk that my service agreement could be terminated. ***The foregoing provision applies only to individual member policies. Members who are part of Employer based groups enjoying AHI/HP USA services are covered by the terms and conditions of the Employer group contract. See your Employer for all details.***

• I acknowledge and understand that I may not terminate this Member Agreement for a period of 12 months. I may only terminate this agreement in the first 12 months if I move outside of the coverage area of AHI/HP USA.

• In addition, I acknowledge and understand that AHI/HP USA may terminate this Member Agreement by providing me written notice and any pre-paid monthly care fees will be prorated to the date of termination and refunded to me within ten (10) business days. AHI/HP USA will not terminate this Member Agreement solely on the basis of health status.

The foregoing provision applies only to individual member policies. Members who are part of Employer based groups enjoying AHI/HP USA services are covered by the terms and conditions of the Employer group contract. See your Employer for all details.

• I acknowledge and understand that if I am enrolled in Medicare I will receive a copy of the Medicare Opt-out Agreement for review and signature before my first appointment. (The Opt-out Agreement does not prevent me from receiving current or future Medicare benefits from non-AHI/HP USA providers nor will my AHI/HP USA health care provider(s) seek reimbursement from Medicare for the medical services I receive from AHI/HP USA network providers.

• I understand that a provider will be assigned to me and that I can change my clinician at any time, for any reason. I understand that all reasonable efforts will be made to accommodate my request, but only if my new clinician's patient panel is open to new patients.

Rights and Responsibilities

• I understand that I have the right to receive accurate and easily understood information about AHI/HP USA's health care services, health care professionals and health care facilities. If I speak a language different from my clinician, have a physical or mental disability or do not understand something, I understand that AHI/HP USA or my provider will make their best effort to provide assistance so I can make informed health care decisions. If I require interpreter services beyond what can be provided by AHI/HP USA, professional interpreters may be provided at an additional cost to me.

• In the event of membership termination, I understand that I must complete a written Service Cancellation Form. Any differences in payment between my billing date and the date of cancellation will be refunded to me via the payment method I have chosen for my monthly care fee. I understand that if my account is overdue, I am responsible for resolving the outstanding balance prior to my service cancellation. ***The foregoing provision applies only to individual member policies. Members who are part of Employer based groups enjoying AHI/HP USA services are covered by the terms and conditions of the Employer group contract. See your Employer for all details.***

• I understand that I have the right to considerate, respectful, and nondiscriminatory care from my AHI/HP USA health care provider(s). I also understand that I am responsible for communicating clearly and respectfully with my provider. Should I become dissatisfied with my care or AHI/HP USA services, I agree to notify AHI/HP USA immediately so my concerns may be addressed in a timely manner.

• I understand that I have the right to know all of my treatment options and to participate in my health care decisions. Parents, guardians, family members or other individuals whom I designate may represent me if I cannot make my own decisions.

• I understand that I have the right to speak in confidence with my AHI/HP USA network provider(s) and to have my health care information protected. I understand that AHI/HP USA nor my provider will not disclose my information without my authorization or without a legal obligation to do so. I also understand that I have the right to review and receive a copy of my personal medical record and may request that my health care provider(s) amend my record if I feel it is inaccurate or incomplete.

• I understand that I have the right to a fair, fast and objective review of any complaint I have against my health care provider(s) or any other staff, including complaints about wait times, operating hours, conduct of personnel, business practices, and adequacy of health care services and facilities. I agree to first bring any complaints to the attention of AHI/HP USA staff and to participate in the AHI/HP USA complaint and grievance process.

• In order to receive the best possible care, I agree to be actively involved in my health care decisions and to disclose all relevant information to my AHI/HP USA network provider(s) so that they can help me achieve my health goals. I also agree to inform my AHI/HP USA clinician(s) of any health care services I receive outside of AHI/HP USA (such as emergency room, specialist, or hospital services).

• I understand that I am responsible for not exposing myself or others to disease or danger. I understand that I can receive information from my AHI/HP USA health care provider about protecting the health and safety of myself and others.

This is NOT Insurance; it is a DPCMH model of care plan that meets the ACA requirement for Minimum Essential Coverage when Employer Sponsored.

By my signature below, I agree to become an Aliera member and I agree to the terms outlined in this Member Agreement and Disclosure.

Signature **X**	***Date***
(Please print full name)	***SIGNATURE BY:*** ○ ***Member*** ○ ***Parent*** ○ ***Legal Guardian***

Billing

Billing Frequency: ○ Monthly ○ Quarterly ○ Semi-Annually ○ Annually (Payments are due in advance)

Payment Options

Payment ○ Credit Card ○ ACH	**Total Member Fee $** Drafted on a recurring basis	**Total Enrollment Fee $** One-time fee

Credit Card Name on card:	Card type: ○ Visa ○ MasterCard ○ Discover Card Number: Exp: /
Card billing address:	CVC:

ACH (Please attach a voided company check to this form)	Bank name:	Account type: ○ Checking ○ Savings
Name on account:	Account number:	Routing number:

The following authorization applies only to Individual member plans. Members who are part of Employer based groups enjoying AHI/HP USA services are covered by the terms, conditions, and authorizations of the Employer group contract. See your Employer for all details.

By signing below, I hereby authorize AHI/HP USA to contact me using the information I have provided via online enrollment, and I hereby authorize AHI/HP USA to initiate charges to my credit card, debit card or bank account for my initial and recurring fees and any incidental fees that I incur or have incurred on my account since my last billing date. I understand that the transaction amount is the total of my plan fee plus the plan fees of any individuals on my account This approval is given regardless if the agreement submitted is in my name, the name of the Primary Member listed herein, or the name of one of the dependents listed under the Primary Member. I understand that the plan fees charged to my credit card will be accurately reflected as those shown on the plan or the most recent fees change via notifications issued to the Primary Member (the subscriber) by AHI/HP USA. This authorization is valid until such time as I provide to AHI/HP USA a written notification of cancellation of this plan.

- *This authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until AHI/HP USA has received written notification from me of its termination in such time and in such manner as to afford AHI/HP USA and my financial institution a reasonable opportunity to act on it.*
- *I understand that my participation in AHI/HP USA is continuous and that, by signing below, I authorize recurring credit/debit card charges for the individual listed.*
- *I understand that a $25 fee will be charged to me for declined credit or debit card transactions that are not honored.*

This is NOT Insurance

Signature **X**	***Date***