



# 2006 Alliance Change Form for Reducing Premiums

As shown below in Section A, you may reduce your premium by (1) selecting a higher deductible or a lower coinsurance (if available) within your current plan or (2) changing to a less expensive plan. The additional premium reduction options shown below in Section B may also be available to you. This form cannot be used to upgrade coverage. Complete only those sections that apply to the change(s) you wish to make.

If you have questions or need help completing this form, call 1-866-721-9295. Please print and be sure to SIGN where indicated. If you change your mind while completing this form, be sure to initial and date any corrections you make.

Subscriber's name: last (please print)		first	middle	Current Group no.	Current Identification no.	
Address: street			City	State	Zip Code	County

**A. Plan and/or Option(s) Selected:** Please put a check mark in box 1, 2, 3, 4, 5 or 6 **only** if you are changing from one plan to another. Whether you are changing plans or only changing option(s) within your current plan, check the option(s) you want within the plan, as appropriate. **Note:** The AllianceChoice plan and network are available only in certain counties.

<p>1. <input type="checkbox"/> Alliance</p> <p>Coinsurance — Network/Non-Network (check one):</p> <p><input type="checkbox"/> 100% / 70%</p> <p><input type="checkbox"/> 90% / 70%</p> <p>Deductible* (check one):</p> <p><input type="checkbox"/> \$ 300</p> <p><input type="checkbox"/> \$ 600</p> <p><input type="checkbox"/> \$ 1,000</p> <p><input type="checkbox"/> \$ 1,500</p> <p><input type="checkbox"/> \$ 2,500</p> <p><input type="checkbox"/> \$ 5,000</p> <p><input type="checkbox"/> \$10,000</p>	<p>2. <input type="checkbox"/> AllianceChoice</p> <p>Coinsurance — Network/Non-Network (check one):</p> <p><input type="checkbox"/> 100% / 70%</p> <p><input type="checkbox"/> 90% / 70%</p> <p><input type="checkbox"/> 80% / 60%</p> <p>Deductible* (check one):</p> <p><input type="checkbox"/> \$0 / \$500†</p> <p><input type="checkbox"/> \$ 500</p> <p><input type="checkbox"/> \$ 1,000</p> <p><input type="checkbox"/> \$ 1,500</p> <p><input type="checkbox"/> \$ 2,500</p> <p><input type="checkbox"/> \$ 5,000</p> <p><input type="checkbox"/> \$ 10,000</p> <p>†Network/Non-Network</p>	<p>3. <input type="checkbox"/> RateSaver</p> <p>Coinsurance — Network/Non-Network (check one):</p> <p><input type="checkbox"/> 100% / 70%</p> <p><input type="checkbox"/> 80% / 50%</p> <p>Deductible* (check one):</p> <p><input type="checkbox"/> \$ 1,000</p> <p><input type="checkbox"/> \$ 1,500</p> <p><input type="checkbox"/> \$ 2,500</p> <p><input type="checkbox"/> \$ 5,000</p> <p><input type="checkbox"/> \$10,000</p> <p>Provider Network (check one):</p> <p><input type="checkbox"/> Alliance</p> <p><input type="checkbox"/> AllianceChoice</p>	<p>4. <input type="checkbox"/> HSA-Compatible Medical Plan</p> <p>Coinsurance — Network/Non-Network (check one):</p> <p><input type="checkbox"/> 100% / 70% <input type="checkbox"/> 90% / 60%</p> <p><input type="checkbox"/> 80% / 50%</p> <p>Deductible* (check one):</p> <p>If coverage is for Applicant only:</p> <p><input type="checkbox"/> \$1,050 † <input type="checkbox"/> \$2,000</p> <p><input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000**</p> <p>If coverage is for Applicant and other family members:</p> <p><input type="checkbox"/> \$2,100 † <input type="checkbox"/> \$ 4,000</p> <p><input type="checkbox"/> \$6,000 <input type="checkbox"/> \$10,000**</p> <p>†This amount changes for federal cost-of-living adjustments.</p> <p>**Available only with 100% / 70% coinsurance.</p> <p>Provider Network (check one):</p> <p><input type="checkbox"/> Alliance <input type="checkbox"/> AllianceChoice</p>	<p>5. <input type="checkbox"/> Hospital/Surgical Plan</p> <p>Provider Network (check one):</p> <p><input type="checkbox"/> Alliance</p> <p><input type="checkbox"/> AllianceChoice</p> <p>Deductible* (check one):</p> <p>If coverage is for Applicant only:</p> <p><input type="checkbox"/> \$1,050 †</p> <p><input type="checkbox"/> \$2,000</p> <p><input type="checkbox"/> \$3,000</p> <p>If coverage is for Applicant and other family members:</p> <p><input type="checkbox"/> \$2,100 †</p> <p><input type="checkbox"/> \$4,000</p> <p><input type="checkbox"/> \$6,000</p> <p>Provider Network (check one):</p> <p><input type="checkbox"/> Alliance <input type="checkbox"/> AllianceChoice</p> <p>†This amount changes for federal cost-of-living adjustments.</p> <p>For extra premium, do you wish to add optional Mental Health &amp; Substance Abuse benefits for yourself and any covered family members?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If added, these benefits replace the substance abuse benefits included in plan.</p>	<p>6. <input type="checkbox"/> HSA-Compatible Hospital/Surgical Plan</p> <p>Deductible* (check one):</p> <p>If coverage is for Applicant only:</p> <p><input type="checkbox"/> \$1,050 †</p> <p><input type="checkbox"/> \$2,000</p> <p><input type="checkbox"/> \$3,000</p> <p>If coverage is for Applicant and other family members:</p> <p><input type="checkbox"/> \$2,100 †</p> <p><input type="checkbox"/> \$4,000</p> <p><input type="checkbox"/> \$6,000</p> <p>Provider Network (check one):</p> <p><input type="checkbox"/> Alliance <input type="checkbox"/> AllianceChoice</p>
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\*Deductible amounts are for charges in and out of network, except as noted.

## B. Additional Options\*:

- Reduce my premium by deleting my maternity coverage. (If reinstated later, maternity benefits will apply only to subscriber or covered spouse, and will not begin until one year after the date added.)
- Reduce my premium by adding a \$1,000 deductible to my coverage for Tier 2 and Tier 3 prescription drugs.
- Reduce my premium by replacing the regular prescription drug coverage of my plan with generic drug benefits. (With this option, you pay a \$15 copay for covered generic drugs and receive a discount on brand-name drugs.)

\*Important: Options 1 and 2 are not available with the RateSaver or the Hospital/Surgical Plans. Options 2 and 3 are not available with the HSA-Compatible Medical Plan. Option 3 cannot be checked on this form for the Hospital/Surgical or the HSA-Compatible Hospital/Surgical Plans, because it would increase premium and require medical underwriting.

**Change Form Agreement** (Read and SIGN below): I understand and agree that if I have omitted or overlooked any information needed to process my Change Form, an employee of the Companies may contact me by phone to obtain the information. Then they may add or correct it directly on my Change Form. All changes or additions made during the phone call will be detailed in a verification letter that will be mailed to me with a copy of my updated Change Form. I understand that if, within 10 business days after the letter is mailed, I have not contacted the Companies with any further clarifications, the letter will become part of my Change Form.

I understand that the Companies rely upon the information provided on this form. If I omit any information or provide any false or incomplete information that

is considered fraud or material misrepresentation, this can result in the cancellation of my coverage based on the terms of my Certificate. I agree to repay promptly any benefit payment to which I or my dependents were not entitled.

I understand that if I wish at a later date to change back to my earlier benefit plan and/or option(s), or otherwise upgrade my coverage, I must complete a Health History questionnaire and satisfy medical underwriting requirements.

I hereby authorize the Companies to take the actions requested herein. I certify that all information provided is true and correct.

I understand that if I am represented by an independent broker or agent, that will not be affected by changes requested on this form.

Subscriber's signature:

X

(Subscriber's Signature if Age 18 or Older/Parent's or Legal Guardian's Signature for Children Under Age 18)

X

(Date)

(Note to parents/legal guardians: If your child is under age 18 and is applying for changes in his/her own membership, please sign as indicated below to show your consent.) No action will be taken without the required signature. If the date of signature is left blank, we will use the date we receive this Change Form.

The Companies are Healthy Alliance® Life Insurance Company (HALIC), its parent, RightCHOICE® Managed Care, Inc. (RIT), and certain affiliates. Blue Cross Blue Shield of Missouri is the name RIT uses to do business in most of Missouri. RIT and certain affiliates administer benefits underwritten by HALIC. RIT and HALIC are independent licensees of the Blue Cross and Blue Shield Association.