4646 West Lake Park Boulevard
Salt Lake City, UT 84120-8212
801-442-5038/800-538-5038
www.selecthealth.org

selecthealth
AN INTERMOUNTAIN HEALTHCARE COMPANY

Individual Plans Application Form

January 09

Please use dark ink and print legibly

A. APPLICANT INFORMATION (Must be oldest family member applying for coverage)

Last Name ______ First Name ______ Middle Initial ______

Mailing Address ______ Unit# ______ Marital Status ❑ Single ❑ Legally Married ❑ Separated ❑ Divorced

City ______ State ______ ZIP ______

Street Address (if different) ______

City ______ State ______ ZIP ______

Your Occupation ______ Your Spouse's Occupation ______

E-mail Address ______ Home Ph# (____) ______ Work Ph# (____) ______

Please check one of the following boxes ❑ New Application ❑ Dependent Addition ❑ Re-apply

Payment Option ❑ Preauthorized Banking Withdrawal ❑ Online Billing and Payment (See Payment Selection Form, p. 7)

B. APPLICANT AND DEPENDENT INFORMATION

IN THE SECTION BELOW, LIST YOURSELF AND ELIGIBLE FAMILY MEMBERS TO BE INCLUDED UNDER MEDICAL COVERAGE.

RELATIONSHIP	NAME (FIRST, MIDDLE INITIAL, LAST)	SEX (M/F)	DATE OF BIRTH (MM/DD/YY)	AGE	SOCIAL SECURITY# (FOR INTERNAL USE ONLY)
Self					*
Spouse					
Child					
Child					
Child					
Child					
Child					
Child					
Child					

*APPLICANT SOCIAL SECURITY# REQUIRED WHEN APPLYING FOR HEALTHSAVE PLAN

1. If you are **adding your spouse**, he or she may be deleted from your coverage only under the following circumstances:
   - When your spouse agrees to be deleted from coverage by signing an Individual Plans Change Form; or
   - When proof of a legal divorce or annulment is given (first and last page of the divorce decree and any page in between specifying coverage responsibilities for dependent children if you have elected family coverage).
2. To be eligible for coverage, **children must be younger than age 26, unmarried, and dependent upon you** for 50 percent of their financial support. (Financial dependency is not required for court-ordered dependent coverage.) Any dependent not listed will not be considered for coverage.
3. If you are applying for one-person coverage and have a spouse and/or dependent(s) not included on this application, it is considered a waiver of dependent coverage. Any future dependents (newborn/adopted or otherwise) will not be guaranteed coverage on this plan. To add them to your policy, you will need to submit an application which will require underwriting approval for a future effective date.

C. DUAL COVERAGE/COORDINATION OF BENEFITS INFORMATION

For Dual Coverage/Coordination of Benefit purposes, indicate each individual who will **also be covered** by other medical insurance **while coverage with SelectHealth is in force.** Please do not complete this section if other coverage will be terminated once the SelectHealth coverage is in force.

RELATIONSHIP	NAME OF INDIVIDUALS COVERED BY OTHER INSURANCE	CARRIER NAME	CARRIER PH#	POLICY#	EFFECTIVE DATE (MM/DD/YY)

SELECTHEALTH USE ONLY

Class# ______ **Plan** ______ **Effective Date** ______ **HSA** ❑ **Yes** ❑ **No**

Agent/Broker ______ **Agent/Broker#** ______

Rate Adjustment Percent ______ **Monthly Payment $** ______ **PEC Start Date** ______

Notes

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION FORM.

D. PLAN INFORMATION

SELECT ONE FROM EACH OF THE FOLLOWING: NETWORK, PLAN OPTION, AND ASSOCIATED BENEFIT SECTION

Network	❑ Select Value®	❑ Select Med Plus®	❑ Select Care Plus℠	**Select one network**
Plan Option	❑ HMO/Plus Plan	❑ HealthSave℠		**Select one plan option and complete associated benefit section below**

HMO/PLUS BENEFIT SECTION

For HMO/Plus Plan option, complete this section.

BENEFIT AND DEDUCTIBLE

Select one benefit level (Base, Mid, or High) and one deductible

❑ **Base-Level Plan**

Deductible applies to all services first

- ❑ $250 Medical Deductible ($100 Rx Ded)
- ❑ $500 Medical Deductible ($200 Rx Ded)
- ❑ $1,000 Medical Deductible ($400 Rx Ded)
- ❑ $2,500 Medical Deductible ($1,000 Rx Ded)
- ❑ $5,000 Medical Deductible ($2,000 Rx Ded)

❑ **Mid-Level Plan**

No deductible for office visits with deductible for Rx

- ❑ $250 Medical Deductible ($100 Rx Ded)
- ❑ $500 Medical Deductible ($200 Rx Ded)

❑ **High-Level Plan**

No deductible for office visits, no deductible for Rx

- ❑ $250 Medical Deductible
- ❑ $500 Medical Deductible
- ❑ $1,000 Medical Deductible

COINSURANCE/COPAY

Select one coinsurance/copay amount

- ❑ 70%/30%—$25/$35
- ❑ 80%/20%—$15/$25

HEALTHSAVE BENEFIT SECTION

For HealthSave option, complete this section.

DEDUCTIBLE

Select one deductible either under Single or Family (Deductible applies to all services ***except preventive care****)*

❑ **Single (One person)**

- ❑ $1,500 Deductible (You pay 20% coinsurance after deductible. $5,000 out-of-pocket maximum including deductible)
- ❑ $2,500 Deductible (You pay 20% coinsurance after deductible. $3,500 out-of-pocket maximum including deductible)
- ❑ $2,700 Deductible (You pay 20% coinsurance after deductible. $5,000 out-of-pocket maximum including deductible)
- ❑ $5,000 Deductible (Covered 100% after deductible)

❑ **Family (Two or more)**

- ❑ $3,000 Deductible (You pay 20% coinsurance after deductible. $10,000 out-of-pocket maximum including deductible)
- ❑ $5,000 Deductible (You pay 20% coinsurance after deductible. $7,000 out-of-pocket maximum including deductible)
- ❑ $5,400 Deductible (You pay 20% coinsurance after deductible. $10,000 out-of-pocket maximum including deductible)
- ❑ $10,000 Deductible (Covered 100% after deductible)

SelectHealth has made a concerted effort to design the HealthSave coverage in compliance with the requirements for a High Deducible Health Plan (HDHP) under federal law (Section 223 of the Internal Revenue Code). However, SelectHealth makes no representations or warranties about the legal adequacy of this coverage as an HSA-compatible plan. SelectHealth is not responsible for any issues relating to your use of the coverage in conjunction with an HSA including, without limitation, your compliance with the requirements of the Internal Revenue Code.

HEALTH SAVINGS ACCOUNT VENDOR

SelectHealth's preferred HSA vendor is HealthEquity®. An HSA will be established for you with HealthEquity if you choose this option (see check box below). An administrative fee is included in your premium amount, regardless of whether you choose to use the preferred HSA vendor. As with most HSA vendors, a nominal fee will also be charged if you choose to terminate the account once it has been established.

❑ **I choose to open an HSA account with HealthEquity.**

❑ **I will use another HSA administrator or not open an HSA at this time.**

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AN INTERMOUNTAIN HEALTHCARE COMPANY

Authorization to Disclose Health Information to SelectHealth for Pre-Enrollment Underwriting Purposes

NOTICE: By signing this form, you give SelectHealth the right to gather medical information about you and your dependents for whom you have legal authority to sign (e.g., a minor child). SelectHealth typically gathers both paper and electronic records. This information helps SelectHealth make an educated decision about insuring you and your dependents.

I. AUTHORIZATION

I authorize any health plan and any healthcare provider (including any pharmacy) to disclose medical information about me to SelectHealth for purposes of determining my eligibility for health insurance coverage as requested in the application dated _______________. The medical information I authorize to be disclosed includes any medical information related to my insurability, except for any genetic test results about me or a blood relative of mine.*

*Utah law prohibits insurers from using genetic results for underwriting purposes.

II. INFORMATION FOR APPLICANT AND DEPENDENTS

I understand the following information:

1. I may refuse to sign this authorization, or I may revoke it if I have not been enrolled in SelectHealth by sending my written request to SelectHealth; however, if I do so SelectHealth may refuse to enroll me;
2. A healthcare provider may not condition my treatment on signing this authorization;
3. Another health plan may not condition payment, enrollment, or eligibility for benefits on my signing this authorization;
4. I understand that the information that SelectHealth receives because of this authorization may be redisclosed and no longer protected by federal or state regulation. Items 5 and 6 of this section limit the potential for redisclosure of my information.
5. If SelectHealth does not enroll me, it may not use or disclose the information it receives because of this authorization for any purpose other than underwriting, except as may be required by law (if SelectHealth denies insurance coverage because of an individual's health condition, Utah law requires SelectHealth to tell the applicant specifically what this health condition is);
6. If SelectHealth does enroll me, it will only use information disclosed under this authorization for purposes described in its notice of privacy practices; and
7. Unless revoked, this authorization will remain in effect for underwriting purposes until 60 calendar days from the date SelectHealth has approved or rejected my application.

III. IDENTIFYING INFORMATION/SIGNATURES FOR THE APPLICANT AND DEPENDENTS

Applicant	Date of Birth	Applicant signature	Date Signed
Spouse	Date of Birth	Spouse signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed

*A representative must have legal authority to sign (e.g., a parent/guardian for a minor child). Generally, a spouse and children older than age 18 must sign for themselves.

E. HEALTH INFORMATION

INSTRUCTIONS: Answer each question considering each individual applying for medical coverage. **Circle any specific item(s)** in the question that applies. Give complete and specific details in Sections F and G for each "Yes" (Y) answer.

1. Is anyone currently receiving medical treatment? .... **Y N**
2. Has anyone consulted, been tested, or had treatment by a doctor, chiropractor, counselor, therapist, or other healthcare provider within the past **THREE YEARS**? .... **Y N**
3. Is any family member currently pregnant, or do they have reason to suspect they might be pregnant?...................... **Y N**
4. Are you or your spouse financially responsible for an unborn child, anticipating adoption, applying for, or have applied for adoption?.. **Y N**
5. Do you have any family members who are **not** applying for coverage? If yes, complete **(a)** below................................ **Y N**

   a) List the reason(s) why any family members are not applying for coverage, and describe their health status and where they are currently covered.

   ____

   ____

   ____

6. Has anyone ever chewed or smoked tobacco?.................. **Y N**
7. Has anyone taken any medication, drugs, shots, or remedies in the past **TWELVE MONTHS**? If yes, complete Section G.. **Y N**

8. Within the past **FIVE YEARS** has any proposed member:
   - **a)** Been advised to be hospitalized, have tests, consultation, evaluation, surgery, or use medication(s), **but has not done so**?.......................... **Y N**
   - **b)** Been evaluated for fertility, is infertile, or had a miscarriage or complication(s) of pregnancy? .... **Y N**
   - **c)** Had gallbladder problems, ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, or other digestive problems? .... **Y N**
   - **d)** Had urinary problems or urinary incontinence? .... **Y N**
   - **e)** Had irregular bleeding, abnormal Pap smears/test, pelvic inflammatory disease, endometriosis, prostate or testicular problems, venereal disease, or any disorder of the reproductive system? .... **Y N**
   - **f)** Had migraines, been unconscious, or had epilepsy, seizures, or convulsions?.. **Y N**
   - **g)** Received any mental health counseling, psychotherapy, or had a mental or nervous disorder, depression, stress, or anxiety that required consultation or medication?....................................... **Y N**
   - **h)** Had cysts, growths (except for warts), breast lumps, augmentation, or reduction?...................................... **Y N**
   - **i)** Had a skin disorder that required medical attention?.... **Y N**
   - **j)** Had a thyroid disorder or a disorder of the lymph nodes or lymph system?.. **Y N**
   - **k)** Been treated for chest pain, high blood pressure, or high cholesterol?.. **Y N**
   - **l)** Had any disorder of the eyes, ears, nose, or throat that required treatment? .... **Y N**
   - **m)** Had any back, neck, or spinal problems, or a joint disorder that required medical attention and/or interfered with normal daily activities?........................ **Y N**
   - **n)** Had a problem for which they **have not** sought medical advice or treatment?..................................... **Y N**

9. Within the past **TEN YEARS,** has any proposed member:
   - **a)** Been hospitalized or had surgery? .... **Y N**
   - **b)** Had hepatitis, colitis, a colectomy or ileostomy, rectal disease, spleen problems, jaundice, or other digestive problems? .... **Y N**
   - **c)** Had gout, arthritis, fibromyalgia, lupus, any connective tissue disease or disorder, or any joint replacement? .... **Y N**
   - **d)** Been diagnosed with, had treatment or surgery for, or any indication of, but not limited to, ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc(s), spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis?............................... **Y N**
   - **e)** Had any surgery or treatments for obesity, bulimia, anorexia, weight control, stomach stapling, or gastric bypass?.. **Y N**
   - **f)** Had tuberculosis, asthma, sleep apnea, pleurisy, emphysema, or any disorder of the lungs or respiratory system?.. **Y N**
   - **g)** Been treated for alcohol use or attended Alcoholics Anonymous® for their own alcohol consumption?......... **Y N**
   - **h)** Been treated for drug dependency, abuse, or reaction?. **Y N**
   - **i)** Been a user of any drug not prescribed, such as: opiates, stimulants, depressants, and/or hallucinogens? . **Y N**

10. Has any proposed member **EVER** had any indication of, diagnosis of, or treatment for:
    - **a)** Any birth defect, developmental or learning disability, physical, neurological, neuromuscular, or mental impairment(s)? .... **Y N**
    - **b)** Bipolar disorder, manic depression, schizophrenia, chronic organic brain syndrome, or any other organic brain or psychotic disorders?...................................... **Y N**
    - **c)** A kidney disorder, liver problems, cirrhosis, or pancreatic problems?... **Y N**
    - **d)** Cancer or tumors? .... **Y N**
    - **e)** Diabetes? .... **Y N**
    - **f)** Multiple sclerosis, muscular dystrophy, cerebral palsy, or any other neurological disorder?............................. **Y N**
    - **g)** Any blood disorder, tested positive for Human Immunodeficiency Virus (HIV), or been treated for or been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any disease or disorder of the immune system?............ **Y N**
    - **h)** Any heart condition or problem, heart murmur, heart attack, rapid, slow, or irregular heartbeat, blood clot, stroke, or other circulatory problem?........................... **Y N**

11. Has anyone been unable to work or been unable to perform routine daily functions for more than two weeks (other than for pregnancy)?.................................. **Y N**
12. Does anyone have any conditions, symptoms, or problems not otherwise mentioned in connection with answering the above questions? .... **Y N**
13. To your knowledge, has anyone been denied for other health or life insurance or been issued a modified or rated policy?... **Y N**
14. List the applicant's and the applicant's spouse's height and weight below. List weight as it is now and as it was **ONE YEAR** ago.
    - **a) Applicant's Height** ________ ft. ________ in.
      Applicant's Weight ________ now; ________ one year ago
    - **b) Spouse's Height** ________ ft. ________ in.
      Spouse's Weight ________ now; ________ one year ago

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION FORM

F. ADDITIONAL INFORMATION

QUESTION#	FIRST NAME OF INDIVIDUAL	DIAGNOSIS OF ILLNESS INJURY, TREATMENT, TESTING OR MEDICAL TREATMENT	DATE BEGAN (MM/DD/YY)	DATE ENDED (MM/DD/YY)	REMAINING SYMPTOMS OR PROBLEMS	NAME AND PHONE# OF PHYSICIAN OR HOSPITAL

G. PRESCRIPTION MEDICATION INFORMATION

FIRST NAME OF INDIVIDUAL	NAME OF MEDICATION	DOSAGE	DATE BEGAN (MM/DD/YY)	DATE ENDED (MM/DD/YY)	REASON FOR MEDICATION	NAME AND PH# OF PRESCRIBING PROVIDER

H. GENERAL INFORMATION

1. Are you self-employed? .... **Y N**

1a. If you are not self-employed, is any employer reimbursing or paying for any portion of this plan? .... **Y N**

2. Does any listed proposed member live, reside, work, or attend school outside of Utah at any time during the year? .... **Y N**

Please explain "yes" answers to the above questions ______________________

I. PRIOR COVERAGE INFORMATION

Have you had health insurance coverage within the past 63 days? ❑ **Yes** ❑ **No** **If "Yes," list carrier information below.**

If you answered "No," when was the last date you were insured? ______________

Have you EVER been covered under SelectHealth (formerly IHC Health Plans)? ❑ **Yes** ❑ **No**

If "Yes," list Policy# ______________________ **and Policyholder's Name** ______________________

If you have had continuous healthcare coverage not separated by a break in coverage of 63 days or more, your Pre-Existing Condition Waiting Period limitation may be partially or completely waived. To determine if this applies to you, **you must enclose proof of prior coverage**. This could include the following: Certificate of Creditable Coverage from your previous carrier, an Explanation of Benefits (EOB) or other correspondence from a plan or issuer indicating coverage, pay stubs showing payroll deduction for health coverage, a health insurance ID Card; a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third-party statements verifying periods of coverage, any other relevant documents that evidence periods of health coverage, or a telephone call from the Plan or provider to the Plan verifying Creditable Coverage. **These documents must include beginning and end dates of coverage.**

You must also provide the following information:

Policyholder's Name ______________________ Policyholder's Birthdate ______________

Name of Carrier ______________________ Policy# ______________________

Effective Date ______________ Termination Date ______________

Carrier's Address ______________________ Carrier's Ph# (____)______________

Submission of prior coverage information does not automatically waive the Pre-existing Condition Waiting Period limitation. However, failure to provide prior coverage information will result in an automatic 12-month Pre-existing Condition Waiting Period.

J. AUTHORIZATION AND ACKNOWLEDGMENT

I am applying for coverage with SelectHealth along with my listed dependents, if applicable. Once fully signed and executed, SelectHealth and I agree to the terms set forth in the Contract, which shall include this application and the Member Payment Summary. I agree that I am and will act as agent and/or as natural guardian for my spouse and other dependents in dealing with SelectHealth. I understand that the coverage I am applying for shall be extended only if I satisfy SelectHealth's underwriting criteria. I understand that no coverage or benefits for any services will be provided until each person listed is approved by SelectHealth. I also understand that unless expressly provided in the Contract, benefits will not extend beyond the termination of either my coverage or the Contract.

The information that I have presented in this application is true and complete. I understand that I have a continuing responsibility to report to SelectHealth eligibility changes for myself or any dependents listed on this application who become members.

I understand that the Contract may limit my choice of healthcare providers and the services they provide, and I agree that to the extent I do not abide by the terms of the Contract, healthcare services I obtain may be denied.

Notice to applicant regarding replacement of accident and sickness insurance. If you intend to replace existing accident and sickness insurance with the coverage you are applying for through this application, please consider the following:

1. Pre-existing conditions may not be immediately or fully covered under the new plan. This could result in the denial or delay of a claim that would have been payable under your present policy or plan.
2. You may wish to talk to your present insurer or its agent regarding the replacement of your present policy. This is your right, and you would be wise to make sure you understand the relevant factors involved in replacing your present coverage.
3. Should you be approved for coverage, you may cancel your new policy within ten days without cost.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the health information on pages four and five, is true and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. If I subsequently become aware of information different from that provided in this application, I agree to provide that additional information promptly to SelectHealth.

K. SIGNATURE OF APPLICANT AND SPOUSE

Applicant Sign and Date Here

Signature ______________________________ **Date Signed** ______________

Spouse's Signature ______________________________ **Date Signed** ______________

(Required if applying for coverage)

L. AGENT/BROKER AGREEMENT (IF APPLICABLE)

I understand and agree that in acting as the agent/broker for this applicant:

1. The application was completed by the applicant;
2. I am in possession of a valid license issued by the state of Utah that authorizes me to sell and service health insurance contracts;
3. I have no authority to: a) make, alter, interpret, or discharge an application or contract in the name of SelectHealth, or b) waive any of the terms of conditions of the Contract.
4. I have no authority to assign effective dates or to affect member changes.
5. Cancellation of this Healthcare Agreement by either the subscriber or SelectHealth will terminate this Agency Agreement.

Date application received at SelectHealth, Inc.

Agent/Broker Name ____________________ **Agency** ____________________ **Ph#(____)**____________________

Agent/Broker Sign and Date Here

Agent Signature ______________________________ **Date Signed** ______________

Requested Effective Date ______________

Coverage is not in force until your application is approved and an effective date is determined by SelectHealth.

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION FORM.

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Individual Plans Payment Selection Form

Applicant's Name ______________________ **Applicant's Social Security OR Subscriber ID#** ______________________
(internal use only)

A. PAYMENT SELECTION

Please select one of the two available methods of payment for your monthly premium. **Your employer cannot** pay any portion of your premium, either directly or through reimbursement. Submit only personal account information.

❑ **Preauthorized Banking Withdrawal**
(Complete section B)

❑ **Online Billing and Payment**
(Complete Section C. You must include a check for the first month's premium.)

B. PREAUTHORIZED BANKING WITHDRAWAL

If you select this method of payment for your monthly premium, your payment will automatically be deducted from your checking/savings account each month. Please complete the information below.

I (we) authorize SelectHealth to initiate debit entries to my (our) ❑ **Checking Account** ❑ **Savings Account**

Account Holder's Name ______________________ **Account#** ______________________

Financial Institution ______________________ **Routing & Transit#** ______________________

I (we) understand that debit entries will be submitted to my (our) account on or about the tenth of each month, regardless of the policy effective date. I (we) understand that a **$25.00 service charge** will be assessed if the premium amount cannot be deducted from my (our) account for any reason.

Account Holder's Signature ______________________ **Date** ____________

PREAUTHORIZED BANKING WITHDRAWAL

Attach a Voided Check Here

Do not use a checking deposit slip for checking withdrawal.
Checking deposit slips do not always contain the necessary routing and transit information.

Check# — 001099
Routing & Transit# — 124004941
Account# — 1839401923

C. ONLINE BILLING AND PAYMENT

If you have selected the Online Billing and Payment option, complete and sign the agreement below. You will receive your monthly statement by e-mail. This e-mail will link you to a Web site where you can make your monthly payment by electronic check or by credit card.

This method of payment requires that you submit the first month's premium using a check or credit card with your application. Premium payments are due on the first day of each month.

Credit/Debit Card (for first month's premium **only**)
Select Card Type
❑ Visa ❑ MasterCard® ❑ Discover® ❑ American Express®

Card# ______________________ Expiration Date ______________________

Name on Card ______________________ Billing ZIP ______________________

Card Holder's Signature ______________________

Applicant's Signature ______________________ **Applicant's Ph#(____)**______________

E-mail Address ______________________ **Applicant's Date of Birth** ______________

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Application Checkoff List

BEFORE YOU SUBMIT YOUR APPLICATION FORM, DID YOU REMEMBER TO...

- ☐ **Complete Sections A to K**
- ☐ **Read Section J —** Authorization and Acknowledgement
- ☐ **Sign Section K —** Signature of Applicant and Spouse
- ☐ **Sign the Payment Selection Form**
- ☐ **Include the first month's premium** (applies to the Electronic Billing and Payment option)
- ☐ **Attach a voided check for Preauthorized Banking Withdrawal**

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