selecthealth℠
AN INTERMOUNTAIN HEALTHCARE COMPANY

selecthealth℠
BENEFIT ASSURANCE COMPANY

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

New Group Data Summary Small Employer

Use this form for new group submissions only.

Company Name _____

Street Address _____

City _____ State _____ ZIP _____ Ph# (_____) _____

Company Key Contact _____ Company Fax# (_____) _____

Billing Address (If different than above, e.g., P.O. Box) _____ Billing Contact _____

City _____ State _____ ZIP _____ Billing Ph# (_____) _____

Proposed Effective Date _____ Writing Agent/Broker Name _____ Ph# (_____) _____

General Agency (GA) Affiliation, if applicable _____

Name of current group carrier, if applicable _____ Coverage dates: From _____ To _____

Reason for changing carriers ❑ Rate increase ❑ Poor service ❑ Benefits ❑ Other _____

Federal tax ID# _____ Number of years in business _____

Employer contribution amount — $ amount OR % amount (minimum 50%) Employee _____

Total number of full-time employees now _____ Total number of full-time employees one year ago _____

Are any employees eligible for or on COBRA, or Utah mini-COBRA? ❑ Yes ❑ No *(If yes, each employee must submit a completed Employee Application)*

Have all employees completed and signed their own application? ❑ Yes ❑ No Employer Initials _____ Agent/Broker Initials _____

Have you elected 24-Hour Coverage (for owners and partners only; $25 per person/per month)? ❑ Yes ❑ No

Payment method ❑ Preauthorized Banking Withdrawal ❑ Web Pay ❑ Monthly Payment (add $25 monthly administration fee)

A. OPEN PANEL (If you are selecting HealthSave℠, Dual Option, or Select Choice℠ Premier leave this section blank)

SELECT FROM THESE OPTIONS FOR OPEN PANEL

Medical Deductible Option ❑ $250 ❑ $500 ❑ $1,000 ❑ $2,000

Coinsurance and Copay (PCP/SCP)

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

Deductible for Office Visits/Prescription Drugs

❑ Waiver of Deductible for Office Visits — Select **one** of the two prescription drug options below:
❑ Rx Deductible Waiver ❑ Rx Deductible* (per person/calendar year)

❑ No Waiver of Deductible for Office Visits or Rx

Maternity Option ❑ Covered as any other illness ❑ Separate $6,500 maternity deductible, per pregnancy (required for groups with 15+ employees)

Mental Health Option ❑ 50%/50% benefit ❑ Catastrophic benefit (rates to be determined by underwriting)

Supplemental Accident Option ❑ Yes ❑ No

***If your Medical Deductible is**	$250	$500	$1,000	$2,000
Your Rx Deductible is	$75	$125	$350	$1,000

B. SELECTHEALTH DENTAL (Available with all plans)

Dental Deductible ❑ $0 ❑ $50 ❑ $100

Annual Maximum Benefit ❑ $1,000 ❑ $1,500 ❑ $2,000

Orthodontics (for contributory plans with at least five enrolling employees only) ❑ Yes ❑ No

If yes, choose life time maximum ❑ $1,000 ❑ $1,500

Nonparticipating Coinsurance (Traditional is 80% preventive/60% basic/40% major) ❑ Upgrade to 100% preventive/80% basic/50% major

Prior Coverage ❑ Yes, with orthodontics ❑ Yes, without orthodontics ❑ No

Employer Contribution ❑ Yes (50% or more) ❑ No

C. HEALTHSAVE PLAN (If you are selecting Open Panel, Dual Option, or Select Choice Premier, leave this section blank)

SELECT FROM THESE OPTIONS FOR HEALTHSAVE

Deductible Option* (Single/Family)		Coordinating out-of-pocket maximum
❑ **1**	$1,500/$3,000	$5,000/$10,000
❑ **2**	$2,500/$5,000	$3,500/$7,000
❑ **3**	$2,700/$5,400	$5,000/$10,000
❑ **4**	$5,000/$10,000	$5,000/$10,000

Maternity Option ❑ Covered as any other illness (required for groups with 15+ employees) ❑ Not covered

Mental Health Option ❑ 50%/50% benefit ❑ Catastrophic benefit (rates to be determined by underwriting)

Health Savings Account ❑ Yes ❑ No

By choosing yes, you have selected to use HealthEquity®, SelectHealth's preferred vendor for HSA administration. Account fee is $2.25 per account holder per month and will be included on your monthly bill.

E. DUAL OPTION PLAN (If you are selecting Open Panel, HealthSave, or Select Choice Premier, leave this section blank)

SELECT FROM THESE OPTIONS FOR DUAL OPTION

OPTION	HEALTHSAVE PLAN	TRADITIONAL PLAN
❑ **1**	Select Care Plus℠ HealthSave $1,500/$3,000 Ded., 20% Coins., $15/$25 Copay	Select Value℠ $250/$750 Ded., 20% Coins., $15/$25 Copay
❑ **2**	Select Care Plus HealthSave $1,500/$3,000 Ded., 20% Coins., $15/$25 Copay	Select Med Plus℠ $500/$1,000 Ded., 20% Coins., $25/$35 Copay
❑ **3**	Select Med Plus HealthSave $1,500/$3,000 Ded., 20% Coins., $15/$25 Copay	Select Med Plus $1,000/$2,000 Ded., 20% Coins., $25/$35 Copay
❑ **4**	Select Care Plus HealthSave $1,500/$3,000 Ded., 20% Coins., $15/$25 Copay	Select Med Plus $1,000/$2,000 Ded., 20% Coins., $15/$25 Copay
❑ **5**	Select Care Plus HealthSave $1,500/$3,000 Ded., 20% Coins., $15/$25 Copay	Select Med Plus $1,000/$2,000 Ded., 20% Coins., $15/$25 Copay
❑ **6**	Select Care Plus HealthSave $1,500/$3,000 Ded., 20% Coins, $15/$25 Copay	Select Care Plus $1,000/$2,000 Ded., 20% Coins., $25/$35 Copay
❑ **7**	Select Care Plus HealthSave $2,700/$5,400 Ded., 20% Coins., $15/$25 Copay	Select Med Plus $1,000/$2,000 Ded., 30% Coins., $25/$35 Copay

Mental Health Option ❑ 50%/50% benefit ❑ Catastrophic benefit (rates to be determined by underwriting)

Health Savings Account ❑ Yes ❑ No

By choosing yes, you have selected to use HealthEquity, SelectHealth's preferred vendor for HSA administration. Account fee is $2.25 per account holder per month and will be included on your monthly bill.

F. SELECT CHOICE PREMIER (If you are selecting Open Panel, HealthSave, or Dual Option, leave this section blank)

SELECT FROM THESE OPTIONS FOR SELECT CHOICE PREMIER

Medical Deductible Option ❑ $250 ❑ $500 ❑ $1,000 ❑ $2,000

Deductible for Office ❑ Waiver of Deductible for Office Visits—Select **one** of the two prescription drug options below.

❑ Rx Deductible Waiver ❑ Rx Deductible* (per person/calendar year)

❑ No Waiver of Deductible for Office Visits or Rx

Maternity Option ❑ Covered as any other illness (required for groups 15+) ❑ Separate $6,500 maternity deductible

Mental Health Option ❑ 50%/50% benefit ❑ Catastrophic benefit (rates to be determined by underwriting)

Supplemental Accident Option ❑ Yes ❑ No

***If your Medical Deductible is**	$250	$500	$1,000	$2,000
Your Rx Deductible is	$75	$125	$350	$1,000

Select Choice Premier is underwritten (insured) by SelectHealth Benefit Assurance Company and administered by SelectHealth.

E. NATIONCARE (Available with an HMO, PLUS, Premier, or HealthSave plan only)

NationCare ❑ Check here to add NationCare for out-of-state employees

Supplemental accident and dental coverage are not available for out-of-state employees. If the in-state office visit copay is $15/$25 or $25/$35, the NationCare copay is $20 or $30, respectively.

G. SIGNATURE

Employer Signature _____ **Date** _____

Agent/Broker Signature _____ **Date** _____

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