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selecthealth.

Employee Dental Application Small Employer

For instructions regarding this application, please refer to section "E. Dental Enrollment Instructions and Additional Information."

A. EMPLOYEE INFORMATION

Last Name _____ First Name _____ Initial _____ Social Security# _____

Street Address _____ Unit# _____ Status ❑ Single ❑ Legally Married ❑ Separated ❑ Divorced

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

Work Ph# (____) _____ Company Name _____ Full-Time Hire Date* _____

# of Hours Worked Weekly _____ Job Title _____

*Full-Time Hire Date is the first day physically at work, working 30 hours or more per week consistently. Providing an incorrect hire date could result in coverage being delayed or denied.

CHECK THE APPROPRIATE BOX ❑ New Group ❑ New Hire ❑ Open Enrollment ❑ Dependent Addition ❑ Special Enrollment Event*

Are you adding a dependent because of a court or administrative order? ❑ Yes ❑ No (If yes, please attach a copy of the notice to this form.)

*If you and/or your eligible dependent(s) are enrolling as a result of a special enrollment event, check all that apply:

❑ Adoption ❑ Marriage ❑ Involuntary Loss of Other Coverage ❑ Utah Premium Partnership

An employee application for a special enrollment event must be submitted within 31 days of the event.

B. COVERAGE AND DEPENDENT INFORMATION (BASED ON THE PLAN DESIGN SELECTED BY YOUR EMPLOYER)

❑ Yes, I would like SelectHealth Dental®. (If you would not like SelectHealth Dental coverage, complete section "D.")

EMPLOYEE AND DEPENDENT INFORMATION (List yourself and eligible dependent(s) to be covered)

RELATIONSHIP	NAME (FIRST, MIDDLE INITIAL, LAST)	SEX	DATE OF BIRTH (MM/DD/YY)	AGE	SOCIAL SECURITY#	OTHER DENTAL INS.	NAME OF OTHER DENTAL INSURANCE CARRIER
EMPLOYEE		M/F				Y/N	
SPOUSE		M/F				Y/N	
CHILD		M/F				Y/N	
CHILD		M/F				Y/N	
CHILD		M/F				Y/N	
CHILD		M/F				Y/N	

C. COVERAGE OPTIONS (BASED ON THE PLAN DESIGN SELECTED BY YOUR EMPLOYER)

If an employer has chosen the SelectHealth Dental plan, employees can enroll in one of the three options below. Since SelectHealth Dental (full dental plan) includes pediatric dental coverage, employees should select a EHB Pediatric Dental option if they don't want a full dental plan but still need to meet the Affordable Care Act (ACA) requirement to have Marketplace-certified pediatric dental coverage. Regardless of age or whether they have dependents, employees who do not currently have the required pediatric dental coverage will need to enroll in a Marketplace-certified dental plan or receive pediatric dental coverage as part of another medical plan, including through a spouse's coverage. Our Essential Health Benefit (EHB) Pediatric Dental meets this requirement and covers two yearly exams, cleanings (including fluoride treatment), and bitewing X-rays for those under 19. Some employers may only be offering the pediatric dental benefit, in which case their employees can't choose SelectHealth Dental, but should instead choose an EHB copay option.

❑ SelectHealth Dental (full dental plan) ❑ EHB Pediatric Dental 15 ($15 office visit copay) ❑ EHB Pediatric Dental 32 ($32 office visit copay)

D. WAIVER OF COVERAGE

❑ **No, I would not like dental coverage from SelectHealth (If you have other dental coverage, please provide policy information).***

Other Dental Carrier_____ Policy# _____ Policy Type ❑ Group ❑ Individual

Policyholder's Name _____ Relationship to Policyholder _____

***If you are enrolled in a SelectHealth medical plan, we assume that you have pediatric dental coverage (see Section C) through another carrier.**

E. DENTAL ENROLLMENT INSTRUCTIONS AND ADDITIONAL INFORMATION

You must read **Section "F. Authorization and Acknowledgment,"** before signing this application. It contains policy and terms for agreement. All areas of the application should be completed in detail by you. It is your responsibility to read and understand this information and follow the instructions given. Please print legibly in ink. Illegible or incomplete applications will delay processing. The following instructions will help you complete this application. If you need further help, contact your employer or your SelectHealth agent/broker**.**

Section A. EMPLOYEE INFORMATION
An Employee Application for a special enrollment event must be submitted within 31 days of the event in addition to the applicable documentation, which includes a copy of adoption and/or placement papers or marriage certificate. A Certificate of Creditable Coverage (to prove involuntary loss of other coverage) must be submitted as soon as reasonably possible.
Please note: The definition of "Full-Time Hire Date" is as follows: First day physically at work, working 30 hours or more per week consistently. Providing an incorrect hire date could result in coverage being delayed or denied.

Section B. EMPLOYEE AND DEPENDENT INFORMATION
Complete this section with all requested information about you and/or your dependent(s).
If your spouse is enrolled, he or she may only be deleted from your coverage under the following circumstances:

- During your employer's annual open enrollment period;
- When your spouse agrees to be deleted from coverage by signing a 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).

To be eligible for coverage, children must be younger than age 26. Any dependent not listed will not be considered for coverage.

For coordination of benefit purposes, indicate whether or not each individual will be covered by other dental insurance while this dental plan is in force. If you answered yes (Y), indicate the name of the other dental insurance carrier.

NOTE: You must list other dental insurance information for each member applying for coverage in order for SelectHealth/SelectHealth BAC to coordinate benefits with other carriers when necessary. On the same line as the member to be covered, circle Y (Yes) or N (No) to indicate whether they will have other insurance coverage along with SelectHealth's plan. You must also list the name of the dental carrier.

Section C. COVERAGE OPTIONS – Choose a dental plan or benefit based on your needs and what options your employer is offering.

Section D. WAIVER OF COVERAGE – You can waive dental coverage by marking the box in this section. Please indicate if you have other dental coverage, as this information may be need to help your group meet its minimum participation requirements.

Section G. EMPLOYEE SIGNATURE
You must read **Section "F. Authorization and Acknowledgment."** If you read, understand, and agree to the terms stated, sign and date this section.

F. AUTHORIZATION AND ACKNOWLEDGMENT

I hereby apply to be enrolled with my listed eligible dependent(s), if applicable, for coverage with SelectHealth/SelectHealth BAC. In connection with both this Application and any plan coverage that may be obtained, I am acting as agent and/or as natural guardian for my dependent(s). Further, in dealing with SelectHealth/SelectHealth BAC, I appoint my employer to act as agent on behalf of myself and my dependent(s). I understand that coverage is dependent upon the satisfaction of applicable underwriting criteria and is subject to the terms and conditions of my employer's Group Dental Contract with SelectHealth/SelectHealth BAC. I also understand no coverage will be in force until each person listed is approved by SelectHealth/SelectHealth BAC, that no benefits will be provided for any service which begins before coverage is effective, and that except as expressly provided in the Group Dental Contract, benefits will not extend beyond the termination of either my coverage or the Group Dental Contract. I represent that all information provided on this Application is true and complete. I understand that omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or void any coverage issued.

CONSENT AT ENROLLMENT. I understand that the Group Dental Contract may limit the dental providers whose services will be covered. I understand that the Group Dental Contract limits or excludes certain conditions or services applicable to myself, or others included on this Application may not be covered. I agree that to the extent I do not abide by the terms of the Group Dental Contract, dental services I obtain may not be covered. If the Group Dental Contract provides that contributions be made, I authorize my employer to deduct them from my pay.

I hereby declare that to the best of my knowledge and belief, the information given on this Application is correctly recorded, true, and complete. If I subsequently become aware of information different from that provided on this Application, I agree to provide that additional information promptly to SelectHealth/SelectHealth BAC.

By signing this form, I certify that I understand the ACA requirement to have pediatric dental coverage (see Section C) and will adhere to this requirement.

G. SIGNATURE

Employee Signature _____ Date Signed _____ /_____ /_____

H. SELECTHEALTH USE ONLY

Effective Date _____ Renewal Date _____ NHWP ❑ 0 ❑ 1 ❑ 2

Group# _____ Sub group# _____

Agent/broker _____ GA _____