selecthealth

selecthealth SM
BENEFIT ASSURANCE COMPANY

P.O. Box 30192 Salt Lake City, UT 84130-0192 801-442-5038/800-538-5038 **selecthealth.org**

Enrollment Form and Instructions Large Employer

You must read all instructions before completing and signing the Enrollment Form because it contains terms for agreement. If you need help, contact a Human Resources/Personnel representative at your place of employment or call Member Services at **801-442-5038** (Salt Lake area) or **800-538-5038**.

SECTION A. EMPLOYEE INFORMATION

Complete this section with all of the requested information about yourself (the employee applying for coverage).

SECTION B. EMPLOYER USE ONLY

An authorized representative of the employer group must complete this section.

- Group Name, Subgroup Name, and Class Name – This information can be provided by your agent or sales representative.
- Employee's Payroll Status – Indicates the current employment classification of the subscriber. For example, please indicate if he or she is an active employee, on an approved leave of absence, or retired.
- Comments – This section may be used to communicate any other pertinent information to SelectHealth/SelectHealth Benefit Assurance Company.
- Employer's Signature – An authorized representative of the employer must sign and date this section to validate the form.

SECTION C. WAIVER OF COVERAGE

Complete and sign this section if you wish to waive healthcare coverage at this time.

You and your dependents may not be eligible to enroll again until the next open enrollment period established by your employer and SelectHealth/SelectHealth BAC, unless you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance coverage. You may, in the future, be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption (special enrollment event), you may be able to enroll yourself, your spouse, and the new dependent(s) if you request enrollment within 31 days of the special enrollment event.

SECTION D. DEPENDENT INFORMATION

Complete this section with all of the requested information about you and your dependent(s).

- If your dependent child is older than the age limit specified in the agreement with SelectHealth/SelectHealth BAC and your employer, but still eligible for coverage because of a physical or mental disability, you must attach proof of the dependent's disability to this form.
- If you or your eligible dependents have other health or dental (if applicable) insurance, you must complete the Secondary Medical Coverage Form (COB) to facilitate accurate coordination of benefits with other carriers.

If your spouse is added, he or she may only be deleted from your coverage in the following circumstances:

- During your employer's next open enrollment period;
- When proof of a legal divorce or annulment is given to SelectHealth/SelectHealth BAC; or
- When your spouse agrees by signing the Employee Change Form (if allowed by your employer's eligibility rules).

SECTION E. EMPLOYEE AGREEMENT AND SIGNATURE

You must read and understand the following information. After you have read and agreed to the following terms of this form, sign under "Section E. Employee Agreement and Signature." Otherwise, this application and enrollment may not be valid.

- I hereby apply for membership in SelectHealth/SelectHealth BAC for the persons listed on this application (herein referred to as applicants) and agree to submit premiums as required by SelectHealth/SelectHealth BAC or authorize my employer to deduct from my earnings the necessary contributions, if any, required of me. I accept the terms of the group agreement between my employer and SelectHealth/SelectHealth BAC and appoint my employer to act as an agent on my behalf. I understand that said agreement is on file with the employer and SelectHealth/SelectHealth BAC and is available for my inspection. I understand that any intentional material misrepresentation in answering the questions on this application or nonpayment of premiums may result in recision or cancellation of my coverage and that of my dependents.

Enrollment Form (See reverse side for instructions)

I am (Please check one):

❑ A new enrollee ❑ Switching from another SelectHealth plan (list plan) _____ ❑ Switching from another carrier (list carrier) _____

Please make selection(s) below (Form is not complete unless a box is checked)

❑ Select Care℠ ❑ Select Med Plus℠ ❑ SelectHealth Eyewear℠

❑ Select Care Plus℠ ❑ Select Choice℠ ❑ SelectHealth Dental®

❑ Select Value℠ ❑ Select Med℠

A. EMPLOYEE INFORMATION (Please print legibly)

LEGAL NAME (Last) (First) (Middle Initial)

DATE OF BIRTH (MM/DD/YYYY) SOCIAL SECURITY NUMBER

MAILING ADDRESS

CITY STATE ZIP

STREET ADDRESS (if different)

CITY STATE ZIP

HOME PHONE CELL PHONE E-MAIL ADDRESS

SEX
❑ Male ❑ Female

Please select your preferrred language / Seleccione el idioma de su preferencia / Aah shoodi, heedigi sha'a saad ninii ziin?
❑ English ❑ Spanish ❑ Navajo ❑ Other

MARITAL STATUS
❑ Single ❑ Legally Married

If you are enrolling due to a special event, check all that apply:
❑ Birth/adoption ❑ Marriage ❑ Loss of other coverage

EMPLOYEE'S PRIOR COVERAGE You must give proof of prior coverage to SelectHealth/SelectHealth BAC as soon as reasonably possible.

CARRIER _____ DATE COVERAGE ENDED _____ /_____ /_____

B. EMPLOYER USE ONLY (Employer, please provide the following information where applicable to this employee.)

If using HealthEquity® (SelectHealth's preferred vendor) for account administration, employees and dependents age 18 or older must complete the HSA Enrollment and Authorization to Disclose Health Information to HealthEquity Form.

GROUP NAME _____ GROUP # _____

SUBGROUP NAME _____ SUBGROUP # _____

CLASS NAME _____ CLASS ID # _____

HIRE DATE (MM/DD/YYYY) _____ /_____ /_____ EMPLOYEE'S MEDICAL PLAN EFFECTIVE DATE (MM/DD/YYYY) _____ /_____ /_____

EMPLOYEE'S PAYROLL STATUS _____

Comments _____

Employer Signature _____ Date _____ /_____ /_____

C. WAIVER OF COVERAGE

I have been given the opportunity to enroll and choose to waive such coverage. I have read the information in "Section C" on the first page of this Enrollment Form and understand the consequences of my choice to waive coverage. Reason for waiving (check one box):

❑ I already have health insurance through ______________________________.
INSURANCE COMPANY NAME

❑ I do not want to buy health insurance at this time.

❑ I already have dental insurance through ______________________________.
INSURANCE COMPANY NAME

❑ I do not want to buy dental insurance at this time.

Employee Signature ______________________________ Date ______ /______ /______

D. DEPENDENT INFORMATION

Complete this section in full. List all eligible dependents (spouse and children) whom you wish to be covered and elect the coverage desired. List children in order of age. List the relationship of all children and dependents to the employee in the "Relationship" column. If you need more space, use another Enrollment Form (available from SelectHealth).

NUMBER OF DEPENDENTS YOU ARE ENROLLING ______________________

COVERAGE

❑ MEDICAL — **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

❑ DENTAL — DATE OF BIRTH (MM/DD/YYYY) — SOCIAL SECURITY NUMBER

❑ EYEWEAR — SEX: ❑ M ❑ F RELATIONSHIP: ❑ Spouse ❑ Dependent

❑ MEDICAL — **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

❑ DENTAL — DATE OF BIRTH (MM/DD/YYYY) — SOCIAL SECURITY NUMBER

❑ EYEWEAR — SEX: ❑ M ❑ F RELATIONSHIP: ❑ Dependent

❑ MEDICAL — **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

❑ DENTAL — DATE OF BIRTH (MM/DD/YYYY) — SOCIAL SECURITY NUMBER

❑ EYEWEAR — SEX: ❑ M ❑ F RELATIONSHIP: ❑ Dependent

❑ MEDICAL — **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

❑ DENTAL — DATE OF BIRTH (MM/DD/YYYY) — SOCIAL SECURITY NUMBER

❑ EYEWEAR — SEX: ❑ M ❑ F RELATIONSHIP: ❑ Dependent

❑ MEDICAL — **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

❑ DENTAL — DATE OF BIRTH (MM/DD/YYYY) — SOCIAL SECURITY NUMBER

❑ EYEWEAR — SEX: ❑ M ❑ F RELATIONSHIP: ❑ Dependent

Are you and/or your ex-spouse required by a divorce decree to pay the medical expenses of your dependent(s)? ❑ Yes ❑ No

If yes, you must attach a copy of the divorce decree to this Enrollment Form. Include the first page of the decree, the signature page, and any other portion(s) of the decree that specifies responsibility for dependent coverage.

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

Will you or any of your dependent(s) have other health or dental insurance in addition to this plan? ❑ Yes ❑ No If yes, complete COB Form.

E. EMPLOYEE AGREEMENT AND SIGNATURE

This section requires that you turn to the first page of this form and read the information in "Section E. Employee Agreement and Signature."
I hereby certify that I have read, understand, and agree to the terms outlined in "Section E. Employee Agreement and Signature" on the first page of this Enrollment Form. After your employer has approved this form, please keep a copy for your records.

Employee Signature ______________________________ Date ______ /______ /______