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

selecthealth

# Group Medical Application (for new Utah groups)

**Small Employers can apply to SelectHealth for group health coverage as outlined below.**

## AS A REFERENCE, THE FOLLOWING ITEMS ARE REQUIRED TO ENROLL IN HEALTHCARE COVERAGE WITH SELECTHEALTH

**Group Documents:**

- ❑ 1. Completed and signed Group Medical Application (this document)
  **NOTE**: Correct form(s) must be used and signed by owner. The following additional forms may be needed:
  - Group Eyewear Application (page 4 of this document), if applicable
  - NationCare Group Application (for out-of-state contracts)
  - Group Dental Application, if applicable
- ❑ 2. A copy of the Employer's Quarterly Wage List
- ❑ 3. Verification of Common Ownership Form (If applicable)
- ❑ 4. A completed copy of the Group Email Opt-In form if employer communications should be received electronically.

**Group Payment:**

- ❑ 5. A check for the estimated first month's premium amount
- ❑ 6. Completed and signed Payment Authorization Agreement (if using the automatic payment option)

**Employee Forms:**

- ❑ 7. A completed Utah Small Employer Health Insurance Application and Application Supplement Form for each employee enrolling.
- ❑ 8. For each employee that elects a Health Savings Account (HSA) with HealthEquity® on the Application Supplement Form: a completed, signed, and dated Health Savings Account Enrollment and Authorization to Disclose Health Information form for all dependents age 18 and over.

**NOTE: FOR A FINAL QUOTE AND TO ENSURE TIMELY ENROLLMENT PLEASE:**

1) Upload the census and submit your quote through Broker Exchange at selecthealth.org
2) Send applications and the documents listed above to SelectHealth

Coverage is not in effect until you have received written notice from SelectHealth, and SelectHealth reserves the right to determine the effective date of coverage.

## A. PLAN SERVICE AREA

**The service area for each network is listed below:**

**Select Value®**
Davis, Salt Lake, Weber, and Utah counties

**Select Med®/Select Med Plus®**
Beaver, Box Elder, Cache, Davis, Duchesne, Garfield, Iron, Juab, Millard, Morgan, Piute, Salt Lake, Sanpete, Sevier, Summit, Tooele, Uintah, Utah, Wasatch, Washington, Wayne, and Weber counties

**Select Care®/Select Care Plus®**
All counties in Utah

## B. EMPLOYEE RECONCILIATION*

_____ Number of eligible employees**

_____ Number of ineligible employees**

_____ Number of employees waiving due to other coverage

_____ Number of employees waiving without other coverage

_____ Number of employees currently in a new hire waiting period

_____ Number of employees enrolling

* See item No. 2 in Section E for enrollment and participation requirements.

** Eligible employees are owners, officers, partners, and all other employees who work at least 30 hours per week (on average over a 52-week period) wherein an Employer/employee relationship exists and where taxes are deducted from wages.

## C. COMPANY INFORMATION

Company Name _____

Street Address _____

City _____ County _____ State _____ ZIP _____

Ph# (_____) _____ Company Fax# (_____) _____

Billing Address _____

City, State, ZIP _____

Company Key Contact _____ Key Contact E-mail _____

Billing Contact _____ Billing E-mail _____

Key Contact Ph# (_____) _____ Billing Contact Ph# (_____) _____

Business Type ❑ Corporation ❑ Sole Proprietorship ❑ Partnership ❑ Nonprofit ❑ LLC

Organization Type (mark only if applicable) ❑ Association ❑ Common Ownership ❑ Professional Employer Organization (PEO)

Nature of Business _____

Federal Tax ID# _____ Number Of Years In Business _____

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

Name of Current Group Carrier (if applicable) _____

Writing Agent _____ Writing Agent Email _____

Agent's Assistant Contact _____ Agent's Assistant Email _____

GA Affiliation _____ Proposed Group Effective Date _____

## D. MONTHLY PREMIUM

On or before the first day of each month, the Employer shall pay SelectHealth the premium per the rate schedule.

**Payment Method**: ❑ Preauthorized Banking Withdrawal ❑ Web Pay ❑ Monthly Payment

## E. ELIGIBILITY, CONTRIBUTION, AND ENROLLMENT CRITERIA

Mandatory employee eligibility and enrollment requirements that the Employer must satisfy as a condition to the initial and continued effectiveness of this contractual arrangement are as follows:

1. **Employer Monthly Contribution and Minimum Enrollment***

   **Contribution**

   The Employer must contribute an amount equivalent to at least 50 percent of the lowest single coverage monthly Premium. The Employer contribution must be consistent for all employee classes and can be either a percentage of the employee Premium or fixed dollar amount. **Employer Contribution: % Per Employee** _____ **or $ Per Employee** _____

   **Participation**

   For Employers with up to four eligible employees after valid waivers – 100 percent must participate.
   For Employers with five or more eligible employees after valid waivers – 75 percent must participate.

   **Employees waiving coverage due to other coverage will not be counted toward participation. Also, groups enrolling between November 15 and December 15 for a January effective date are not subject to participation and contribution requirements.*

2. **Newly Eligible Employees**

   The Employee's Effective Date will be the first day of the next calendar month following the Employer Waiting Period.*

   **The Employer Waiting Period is:**

   ❑ 0 months (employee is eligible on the first of the month following hire date) ❑ 1 month ❑ 2 months
   **The Employer Waiting Period can only be changed twice—once at renewal and once outside of the renewal period.*

   ❑ Dual waiting periods for separate employee classes (classes determined by Employer—businesses must have five or more enrolled employees to qualify for a dual waiting period)

   **Dual Waiting Periods Are:** _____ /_____

3. **Dependent Age Limitations**
   Dependent children are eligible for coverage up to age 26 (see the Certificate of Coverage for exceptions for disabled children).
4. **Small Group Status**
   It is important to determine whether a group meets the definition of a small employer, as outlined by the Utah Insurance Department. To make this determination, employers should calculate the average number of eligible employees they had on each business day during the previous calendar year (e.g., groups with 2014 effective dates should use the 2013 calendar year). If the average number of eligible employees is greater than 50, the group will be considered a large employer. If the average number of eligible employees is 50 or fewer, the group will be considered a small employer. If SelectHealth will be covering the group's out-of-state employees, then all eligible out-of-state employees should be included in the count.
5. **Termination of Coverage**
   Employee and dependent(s) coverage will terminate as of the end of the month in which termination of eligibility occurs. However, when an event causing loss of eligibility should have resulted in a member's retroactive termination, but the retroactive termination is not allowed under federal or state law, SelectHealth has the discretion to determine the prospective date of termination. SelectHealth also has the discretion to determine the date of termination for rescissions (as defined in the Group Health Insurance Contract).
6. **Leave of Absence**
   Eligible employees are granted a leave of absence by the Employer for up to 60 days.
7. **Employee Status**
   A person may only be considered an employee if the Employer withholds and pays to the government Social Security and Medicare taxes and income tax withholding on the employee's wages.

## F. DURATION OF GROUP HEALTH INSURANCE CONTRACT

If SelectHealth's minimum employee participation and Employer contribution requirements are satisfied, the Group Health Insurance Contract and its terms shall commence on the effective date for a term of 12 months. Groups enrolling between November 15 and December 15 for a January effective date are not subject to participation and contribution requirements.

## G. MEMBER PAYMENT SUMMARY

In addition to any other applicable premium, members shall pay the copay/coinsurance amount per occurrence on the attached Member Payment Summary. "Not Covered" on the Member Payment Summary indicates that the service is not covered regardless of any other statement of coverage.

## H. SIGNATURE

When a separate Employer Plan Coverage List is countersigned by SelectHealth and attached to this document, then this document, the Employer Plan Coverage List, and the Group Health Insurance Contract (including the Member Payment Summary) become the agreement between SelectHealth and Employer. In case of discrepancies, the Group Health Insurance Contract will prevail over this document.

Coverage, if approved, is made on the basis of information provided to SelectHealth by the Employer and its employees and is subject to the above criteria as well as properly completed employee (Subscriber) applications. The Employer understands that SelectHealth is relying on such information in making decisions about coverage and payment. Employee applications must be submitted to and approved by SelectHealth before the proposed effective date. Otherwise, SelectHealth may delay the effective date of issue of this Contract.

This Group Application must be signed by Employer and received by SelectHealth before the Group Health Insurance Contract can be finalized.

Company Name _____

Owner's Signature _____

Owner's Printed Name _____

Date _____

# Group Eyewear Application

**Small employers can apply to SelectHealth for group eyewear coverage as outlined below.**
**Unless otherwise noted below, selections and requirements that apply to medical also apply to eyewear.**

SelectHealth partners with EyeMed Vision Care® as the eyewear vendor for customer service and claims, and for provider access.

## I. PROVIDER ACCESS

SelectHealth Eyewear℠ offers access to providers nationwide.

## J. ELIGIBILITY, CONTRIBUTION, AND ENROLLMENT CRITERIA

1. **Newly Eligible Employees**
   Must be equal to the Employer Waiting Period for medical

2. **Employer Monthly Contribution (select one of the following):**
   - ❑ **Contributory** (Employer must contribute an amount equivalent to at least 75 percent of the single coverage monthly Premium. The Employer contribution must be consistent for all employee classes.)
   - ❑ **Voluntary** (Employer is not required to contribute to the employees' monthly premium.)

3. **Required Minimum Employee Enrollment**
   A minimum of five employees must be enrolled at all times. There is no minimum enrollment percentage for participation.

   _____ Number of employees enrolling for eyewear coverage

## K. OTHER REQUIREMENTS

A group may not purchase SelectHealth Eyewear without also purchasing medical coverage. However, if a group does purchase an eyewear plan along with their medical plan, individual employees may enroll in a group's eyewear coverage for themselves and dependents without also enrolling for medical.

## L. SIGNATURE

When a separate Employer Plan Coverage List is countersigned by SelectHealth and attached to this document, then this document, the Employer Plan Coverage List, and the Group Eyewear Contract become the agreement between SelectHealth and Employer. In case of discrepancies, the Group Eyewear Contract will prevail over this document.

Coverage, if approved, is made on the basis of information provided to SelectHealth by the Employer and its employees and is subject to the above criteria as well as properly completed employee (Subscriber) applications. The Employer understands that SelectHealth is relying on such information in making decisions about coverage and payment. Employee applications must be submitted to and approved by SelectHealth before the proposed effective date. Otherwise, SelectHealth may delay the effective date of issue of this Contract.

This Group Application must be signed by Employer and received by SelectHealth before the Group Eyewear Contract can be finalized.

Company Name _____

Owner's Signature _____

Owner's Printed Name _____

Date _____

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# SMALL EMPLOYER EMAIL OPT-IN FORM

Employer Name _____ Employer ID _____

Broker Name_____

Use this form to sign up for email communication from SelectHealth. We will use your email to send plan-related information such as your contract, Summary of Benefits and Coverage, notification renewal packets, and premium information.

❑ **Yes, I would like to receive communication via email. I further acknowledge that this email address is regularly monitored by a company representative, and I agree to notify SelectHealth of any changes to this email address.**

If you would like to opt out of email communication at any time, please email us at **underwritingoperations@selecthealth.org** with your group name and group ID. In the email, please indicate that you would like to receive paper communication.

Employer Email Address _____

Name (First, MI, Last) _____ Title _____

Signature _____ Date Signed _____ / _____ / _____

Please email this signed form to SelectHealth at **underwritingoperations@selecthealth.org** or your SelectHealth agent. If you would like to change your email address or request a paper copy of the document you received electronically, call **800-442-5306**, and select option 2. All requests will be processed within 5 business days.