UTAH INDIVIDUAL HEALTH INSURANCE APPLICATION

Only for use outside the Federally Facilitated Marketplace

A. APPLICANT INFORMATION

Please check one of the following boxes: ❒ New Application ❒ Dependent Addition

Name (Last) ________________ (First) ________________ (MI) ________

Marital Status ❒ Legally Married ❒ Single ❒ Divorced ❒ Widowed ❒ Domestic Partner

Mailing Address ________________ Apt. ______ City ________________ State ______ Zip ________

Street Address ________________ Apt. ______ City ________________ State ______ Zip ________

Applicant's county of residence: ________________

Home/Cell Phone (_____) ________________ Business Phone (_____) ________________

Driver's License Number: ________________ Email Address: ________________

Are all persons applying for coverage a U.S. citizen or U.S. national? ❒ Yes ❒ No If no, provide name(s):________________

If a person applying for coverage is not a U.S. citizen or U.S. national, do they have eligible immigration status? ❒ Yes ❒ No

If yes, provide your document type and ID number below.

Immigration document type: ________________ Document ID number: ________________

Lived in the U.S. since 1996? ❒ Yes ❒ No Veteran or an active-duty member of the U.S. military? ❒ Yes ❒ No

Is any person applying for coverage incarcerated or jailed? ❒ Yes ❒ No If yes, provide name(s):________________

B. APPLICANT AND DEPENDENT INFORMATION

In the section below, list yourself and all eligible family members to be included under the policy. Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26 unless the child meets the requirements of children with a disability. Any dependent not listed will not be considered for coverage. Attach a separate sheet if necessary.

	Name(Last, First, MI)	Social Security # (for insurer use only)	Date of Birth MM/DD/YYYY	Gender	Tobacco Use
Self				❒ Male ❒ Female	❒ Yes ❒ No
Spouse/ Domestic Partner				❒ Male ❒ Female	❒ Yes ❒ No
Dependent				❒ Male ❒ Female	❒ Yes ❒ No
Dependent				❒ Male ❒ Female	❒ Yes ❒ No
Dependent				❒ Male ❒ Female	❒ Yes ❒ No

Does any listed proposed insured live, reside, work or attend school outside the state of Utah at any time during the year? ❒ Yes ❒ No
If yes, name of proposed insured and % of time outside the state: ________________

C. CURRENT COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, including Medicare or Medicaid, currently in effect. This information will be used to determine if benefits will be coordinated. If no health care coverage was in effect, please indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependents' health care coverage so that the insurer can determine whose coverage is primary. Attach a separate sheet if necessary.

Name of Individual	Insurer (List policyholder name, insurer name and phone number)	Date of Coverage MM/YY Start Date	End Date	Will coverage continue?	Type of Coverage (Check all that apply)
Applicant:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other________
Spouse/ Domestic Partner:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other________
Dependent:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other________
Dependent:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other________
Dependent:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other________

D. EMPLOYMENT INFORMATION

Employer ______________________ Group Insurer ______________________ Job Title ____________ Hrs/Week ______
Spouse's Employer ______________________ Spouse's Group Insurer ______________________ Spouse's Job Title ____________ Hrs/Week ______

1. Is any employer reimbursing or paying for any portion of this policy? ❒ Yes ❒ No
2. Does your employer offer health insurance? ❒ Yes ❒ No
3. Are you self-employed? ❒ Yes ❒ No If self-employed, do you have any full or part-time employees? ❒ Yes ❒ No

E. ACKNOWLEDGMENT & SIGNATURE

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage. When incorporated with the policy, this application will become part of the policy. Once fully signed and executed, insurer and I agree to terms set forth in the policy. In connection with both this application and any coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable eligibility criteria. I also understand that no benefits will be provided for any services which begin before the policy is effective; and that except as expressly provided in the policy, benefits will not extend beyond the termination of either my coverage or the policy.

CONSENT AT ENROLLMENT.
I understand that it is my continuing responsibility to report to the insurer changes in the eligibility of any applicants who become enrolled.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration.

I understand that my choice of health care providers whose services will be covered may be restricted by the policy.

I understand there may not be participating providers in all specialty fields.

I agree that coverage for any services that are obtained without or contrary to required preauthorization/precertification requirements in the policy may be denied

NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH BENEFIT PLAN.
According to information furnished, you may intend to lapse or otherwise terminate an existing health benefit plan and replace it with a new policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I hereby declare that to the best of my knowledge and belief, the information given on this application is correctly recorded, 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 the insurer. A change of information prior to the effective date of the policy may void an offer to provide coverage.**
If any information provided is false or incomplete, the insurer may without advance notice pursue any remedies available under state or federal law, including but not limited to: declaring the policy null and void and canceling the policy retroactive to its original effective date.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I attest that all information on this form is accurate. I have read the Acknowledgment of this document and agree to its terms.

Applicant Signature ____ Date ______________
(A faxed signature shall be valid as an original signature.)

Spouse/Domestic Partner Signature ____________________________________ Date ______________
(Required if applying for coverage. A faxed signature shall be valid as an original signature.)

Requested Effective Date ______________
(Coverage is not in force until the insurer approves your application and determines the effective date.)

F. PRODUCER AGREEMENT AND COMPENSATION DISCLOSURE (If applicable)

I understand and agree that in acting as the producer 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 accident and health insurance;
3. I have no authority to: a) make, alter, interpret, or discharge an application or policy in the name of a insurer; or b) waive any of the terms or conditions of the policy.
4. I have no authority to assign effective dates or to effect member changes.

Producer Name ______________________ License # __________ Agency ____________________ Phone (____) ______________

Producer Signature____ Date Signed____________________

(A faxed signature shall be valid as an original signature.)

Producer Compensation Disclosure:

(Compensation includes commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration.)

I have received written disclosure that the producer will receive compensation from the insurer or a third party administrator for the placement of insurance, including the amount or type of compensation.

Applicant Signature ____ Date ____________________

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

selecthealth.

Individual Plans Utah Application Supplement Form

Applicant's Name ______________________ **Applicant's Social Security# OR Date of Birth** ______________________
(internal use only)

Payment Option ❑ Preauthorized Banking Withdrawal ❑ Online Billing and Payment
(See Payment Selection Form on page 3.)

A. MEDICAL PLAN INFORMATION

Select a network, then select one of the following plans, including any associated benefit options.

Network Options ❑ select:value. ❑ select:med. ❑ select:care.

SELECTHEALTH PREFERENCE℠

Select one deductible.

$250, $500, AND $1,000 DEDUCTIBLE PLANS

- ❑ Gold $250 Medical Deductible ($100 Rx Deductible)
- ❑ Gold $500 Medical Deductible ($250 Rx Deductible)
- ❑ Silver $1,000 Medical Deductible ($1,000 Rx Deductible)
- ❑ Gold $1,000 Medical Deductible ($100 Rx Deductible)

$250, $500, AND $1,000 DEDUCTIBLE PLANS
WITH OFFICE DEDUCTIBLE WAIVER - *Deductible waived for office visits and minor diagnostic testing.*

- ❑ Gold $250 Medical Deductible ($100 Rx Deductible)
- ❑ Gold $500 Medical Deductible ($250 Rx Deductible)
- ❑ Gold $1,000 Medical Deductible (500 Rx Deductible)

$2,500 AND $5,000 DEDUCTIBLE PLANS

- ❑ Silver $2,500 Medical Deductible ($1,000 Rx Deductible)
- ❑ Bronze $5,000 Medical Deductible ($1,000 Rx Deductible)

$2,500 AND $5,350 DEDUCTIBLE PLANS
WITH LIMITED OFFICE VISIT DEDUCTIBLE WAIVER
The deductible is waived for the first four office visits for PCP, SCP, urgent care, and mental health visits combined.
$250 minor diagnostic testing per person per calendar

- ❑ Silver $2,500 Medical Deductible ($1,000 Rx Deductible)
- ❑ Bronze $5,350 Medical Deductible ($1,000 Rx Deductible)

$3,800 DEDUCTIBLE COPAY PLAN

- ❑ Silver $3,800 Medical Deductible ($2,500 Rx Deductible)

SELECTHEALTH HEALTHSAVE℠

Select one deductible.

20 PERECENT COINSURANCE PLANS

- ❑ Silver $1,500/$3,000 Deductible
- ❑ Silver $2,000/$4,000 Deductible

30 PERCENT COINSURANCE PLAN

- ❑ Bronze $3,500/$7,000 Deductible

NO COINSURANCE PLANS

- ❑ Silver $3,500/$7,000 Deductible
- ❑ Bronze $5,500/$11,000 Deductible

SelectHealth designed the HealthSave plans to be in compliance with the requirements for a High Deductible 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 (HSA) VENDOR

The SelectHealth preferred HSA vendor is HealthEquity®. An HSA will automatically be established for you with HealthEquity unless you opt out of this option (see 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 be charged if you choose to terminate the account once it has been established.

Opt Out

- ❑ **I do not plan to open an HSA or plan to use another administrator.**

MILLENNIAL PLAN

CATASTROPHIC PLAN*
Deductible waived for first three PCP, KidsCare, and mental health visits combined per person per calendar year.

- ❑ $6,600/$13,200 Deductible

*For individuals under age 30 or who qualify for a hardship exemption

B. WAIVER OF DEPENDENT COVERAGE

1. Do you have any family members who are **not** applying for coverage? If yes, complete the information below. ❑ Yes ❑ No

   List the name(s), age(s), relationship(s), and reason(s) why any family members are not applying for coverage. Describe their health status(es), and indicate where they are currently covered.

   ____
   ____
   ____

selecthealth.

C. SELECTHEALTH DENTAL® PLAN INFORMATION

TRADITIONAL PLANS

Select a network and then select from one of the following plan options below.

Network Options ❑ Classic ❑ Prime ❑ Fundamental

Select ***one*** *annual maximum.*

Includes a $50 dental deductible

❑ $750 Annual Maximum
❑ $1,000 Annual Maximum
❑ $1,500 Annual Maximum

❑ Add nonparticipating benefits

TIERED PLANS

Includes the Prime and Fundamental networks.

❑ Prime $50 Dental Dedutible
$1,000 Annual Maximum
Fundamental No Dental Deductible
$2,000 Annual Maximum

selecthealth.

Individual Plans Payment Selection Form

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

A. PAYMENT SELECTION

Please select a method 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 be deducted automatically from your checking/savings account each month. Please complete the information below.

I authorize SelectHealth to initiate debit entries to my ❑ **Checking Account** ❑ **Savings Account**

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

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

I understand that debit entries will be submitted to my account on or about the 10th of each month, regardless of the policy effective date. I understand that a **$25.00 service charge** may be assessed if the premium amount cannot be deducted from my 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# Routing & Transit# Account#

001099 124004941 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 website 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 with your application using a check or credit card. 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 ______________________

Cardholder's Signature ______________________

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

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

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

selecthealth.

Application Checklist

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

- ☐ **Complete and sign the Utah Individual Health Insurance Application Form**
- ☐ **Read Section E —** Acknowledgement
- ☐ **Complete and sign the Individual Plans Utah Application Supplement Form**
- ☐ **Sign the Payment Selection Form**
- ☐ **Include the first month's premium** (applies to the Online Billing and Payment option)

© 2014 SelectHealth. All rights reserved. 3564 10/14