UTAH INDIVIDUAL HEALTH INSURANCE APPLICATION

A. APPLICANT INFORMATION

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 _____

Home (or other) Phone (_____) _____ Business Phone (_____) _____

Driver's License Number: _____ Email Address: _____

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, % of time_____

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

B. APPLICANT AND DEPENDENT INFORMATION (attach separate sheet if necessary)

In the section below, list yourself and all eligible family members to be included under coverage.

	Social Security # (for internal use only)	Name(Last, First, MI)	Date of Birth	Age	M/F	Weight	Height
Self						lbs.	
Spouse						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	

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, unmarried, and dependent upon you for 50 percent of their financial support. (Financial dependency is not required for court-ordered dependent coverage.) Any dependent not listed will not be considered for coverage.

C. CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health insurance coverage (including Medicare or Medicaid) in effect within 24 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 24 months, 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 dependent(s)' health care insurance so that the carrier can determine whose coverage is primary.

Enrolling Individual's Name (Non-Medicare)	Insurance Carrier (Including policyholder name, insurer name and phone number)	Date of Coverage Month/Day/Year From	To	Will the individual continue this coverage?	Type of Coverage (Check all that apply)
Self				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Spouse				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Dependent				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Dependent				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Dependent				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Dependent				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical

If you were previously insured on a group plan, have you exhausted your COBRA rights? ☐Yes ☐No ☐NA If "Yes" Date Started _____ Date Ended _____

If COBRA was not an option for you, have you exhausted your Utah mini-COBRA rights? ☐Yes ☐No ☐ NA If "Yes" Date Started _____ Date Ended _____

Have you ever been or are you currently insured through HIPUtah? ☐Yes ☐No If "Yes" Date Started _____ Date Ended _____

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous carrier. Submission of prior coverage information does not automatically waive any PEC limitation. However, you will be subject to an automatic PEC Waiting Period of up to 12 months until we receive evidence of prior coverage.

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 coverage? ❒ Yes ❒ No
2. Are you self-employed? ❒ Yes ❒ No If self employed, do you have any full or part-time employees? ❒ Yes ❒ No

E. HEALTH STATEMENT

IF ANY OF THE BELOW CONDITIONS OR QUESTIONS ARE CHECKED "YES" PROVIDE DETAILS IN SECTIONS G. & H. ON THE FOLLOWING PAGE.

The federal Genetic Information Nondiscrimination Act prohibits health issuers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic tests, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. Do not report genetic information on this form. However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

EACH QUESTION MUST BE CHECKED "YES" OR "NO." This health statement must be complete or the application will be returned. Inaccurate health information may result in the policy being cancelled retroactively. It is your responsibility to notify the carrier of any change in health status while application is pending.

	Respond to the following questions:	YES	NO
1	**Pregnancy/Adoption:** Are you, your spouse, or any dependent family member pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?		
2	**Pregnancy/Fertility Related Treatment:** Are you, your spouse, or any dependent family member being treated for infertility, fertility evaluation or treatment (including medication), miscarriage, complications related to pregnancy (including premature births)?		
3	**Last Menstrual Period:** Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period? If yes, provide date of last menstrual cycle on the following page.		
	Within the past 12 MONTHS has any applicant:	**YES**	**NO**
4	**Prescriptions/Medications/Immunizations:** Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?		
5	**Conditions Requiring Follow Up Medical Consult/Treatment:** Do you, your spouse or any dependent family member have a condition for which hospitalization, tests, consultation, evaluation, surgery, or medication have been advised, but not completed?		
6	**Medical Consult/Treatment:** Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?		
7	**Conditions Requiring Initial Medical Consult/Treatment:** Had a health condition, problem, disorder, or any other medical or mental health conditions not listed for which medical or mental health advice or treatment has not been sought ?		
	Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:	**YES**	**NO**
8	**Urinary, bladder, incontinence, kidney or liver conditions or disorders?** Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?		
9	**Neurological Disorders:** Recurring headaches, migraines, head injury, epilepsy, seizures, or convulsions or other neurological disorder?		
10	**Metabolic and Endocrine Conditions/Disorders:** Lupus, thyroid disorder, goiter, or any other lymph system disorder?		
11	**Eyes, ears, nose, sinus, or throat conditions/disorders** or any other respiratory system disorder including allergies or hay fever?		
12	**Skin Conditions/Disorders:** Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?		
13	**Breast Conditions/Disorders:** Breast lumps, breast augmentation, or breast reduction?		
14	**Heart Conditions/Disorders:** Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?		
15	**Back, neck, bone, joint or spinal disorder:** bone or joint disorders (including foot, knee, jaw, fracture, dislocation or joint replacement)?		
16	**Blood Conditions/Disorders:** Hemophilia, anemia, blood or bleeding disorder?		
17	**Male Reproductive Conditions/Disorders:** Impotence, prostate or testicular disorder, or abnormal PSA or other reproductive disorder?		
18	**Circulatory System Conditions/Disorders:** Varicose veins, or any other circulatory disorder?		
19	**Hospitalization/Surgery:** Have you, your spouse or any dependent family member been hospitalized or had surgery?		
20	**Sexually transmitted diseases**?		

	Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following (cont.):	YES	NO
21	**Female Reproductive Conditions/Disorders:** Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, or pelvic inflammatory disease or any other disorder of the reproductive system?		
22	**Digestive Conditions/Disorders:** Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, any other gallbladder or digestive disorder, hemorrhoids, polyps, or any other rectal disorder?		
23	**Nervous, Mental and Behavioral:** Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication?		
	Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:	**YES**	**NO**
24	**Gout, arthritis, Rheumatoid arthritis, fibromyalgia, or scleroderma?**		
25	**Musculoskeletal Conditions/Disorders:** Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis or other musculoskeletal disorder?		
26	**Digestive Conditions/Disorders:** Crohn's disease. Colitis, colostomy, or ilesotomy or other digestive disorder?		
27	**Alcohol or Drug Use/Abuse:** been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption, drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?		
28	**Eating Disorders/Obesity Treatment:** including bulimia, anorexia, or obesity and any surgical services for obesity.		
29	**Respiratory Conditions/Disorders:** RSV, reactive airway disease, tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, emphysema?		
30	**Tobacco** use (chewing or smoking)? Quit Date: _____		
	Has any applicant EVER been diagnosed with or treated for any of the following:	**YES**	**NO**
31	**Birth Defects/Congenital Abnormalities:** premature birth, development or learning disability, mental impairment, Down syndrome, or autism spectrum disorder?		
32	**Nervous, Mental and Behavioral:** Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?		
33	**Transplant or Implanted Device**: Any organ or tissue transplant, pacemaker or other implanted device?		
34	**Immune System Conditions/Disorders:** Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?		
35	**Brain/Nervous System Conditions/Disorders:** Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?		
36	**Diabetes** (type I or II), insulin resistance?		
37	**Heart and Circulatory Conditions/Disorders:** Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, or coronary artery disease, or congestive heart failure?		
38	**Cancer/Tumors:** (including skin cancer or melanoma) or tumors?		
39	**Urinary/Liver Conditions/Disorders:** Cirrhosis, hepatitis, or renal failure?		
	OTHER MEDICAL INFORMATION	**YES**	**NO**
40	Any medical condition or treatment that you are unsure of where it fits in above? _____		

F. DISABILITY INFORMATION

Are you or any dependent(s) disabled? ❒ Yes ❒ No If yes, indicate first and last name(s). _____
Reason for disability: _____
Is the disabled dependent unable to perform routine daily functions for two weeks or more? ❒ Yes ❒ No

Have you or any dependent(s) filed workers' compensation claims or disability claims within the last five years? ❒ Yes ❒ No
If so, what is the status of the claims? _____

G. ADDITIONAL INFORMATION (Attach a separate sheet for additional information if necessary)

Question #	Name of Individual	Diagnosis, illness, injury, treatment received, testing, medical attention, medications, future treatments	Start Date mm/dd/yy	End Date mm/dd/yy	Remaining symptoms or problems	Name & phone of physician or hospital	
						Name	Phone #

H. PRESCRIPTION INFORMATION WITHIN LAST 12 MONTHS (Attach a separate sheet for additional information if necessary)

Question #	Name of individual	Name of Medication	Dosage	Start Date mm/dd/yy	End Date mm/dd/yy	Reason for medication	Name & phone of physician or hospital	
							Name	Phone #

I. 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, carrier 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 underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved; that no benefits will be provided for any services which begin before the coverage 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 no producer or carrier representative is allowed to permit me to answer any question inaccurately, untruthfully, or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to the carrier 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, and I agree that coverage for any services that are obtained without or contrary to required preauthorization/precertification requirements in the policy may be denied. I understand the coverage for which I am applying may limit or exclude certain conditions, regardless of whether or not they are pre-existing. I also understand that the coverage may limit or exclude conditions for which a family member or I have received, or have been recommended to receive, any medical advice, diagnosis, care, or treatment during the six months immediately preceding the date I apply for coverage, according to the pre-existing conditions limitation provisions of the policy.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE. According to information furnished, you may intend to lapse or otherwise terminate existing accident and health insurance 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.
1. Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new plan. This could result in a denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. 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.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history.
4. Failure to include all material medical information on an application may provide a basis for the carrier to deny any future claims and to refund your premium as though your policy had never been in force. 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, including the health information on pages three and four of 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 carrier.

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

I understand that credit for prior coverage will be based upon the information contained in this application. If any information provided is false, the insurer may without advance notice declare the contract null and void and cancel the coverage retroactive to its original effective date or impose the pre-existing condition waiting period and deny claims that are pre-existing.

I further certify that all information completed on this form is true, correct and complete and acknowledge my coverage is subject to cancellation or other action permissible at law, if any completed information is found to be false or incorrect.

Any matter in dispute between myself and the Plan 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 Plan. The Plan 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 myself and the Plan. 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. I have also completed the Authorization to Disclose Protected Health Information form that accompanies this application.

Applicant Signature _____ Date _____

Spouse's Signature _____ Date _____
(Required if applying for coverage)

Requested Effective Date _____

Coverage is not in force until the carrier approves your application and determines the effective date.

J. 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 health insurance contracts;
3. I have no authority to: a) make, alter, interpret, or discharge an application or contract in the name of a carrier; 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 _____ Agency _____ Phone (____) _____

Producer Signature _____ Date Signed _____

Producer Compensation Disclosure:

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 _____

selecthealth℠

Authorization to Disclose Health Information to SelectHealth for Preenrollment Underwriting Purposes

NOTICE: By signing this form, you give SelectHealth the right to collect medical information about you and your dependents for whom you have legal authority to sign (e.g., a minor child). SelectHealth typically collects both paper and electronic records. This information helps SelectHealth make an educated decision about insuring you and your dependents.

I. AUTHORIZATION

I authorize any health plan and any healthcare provider (including any pharmacy) to disclose medical information about me to SelectHealth for purposes of determining my eligibility for health insurance coverage as requested in the application dated _____. The medical information I authorize to be disclosed includes any medical information related to my insurability, except for any genetic test results about me or a blood relative of mine.*

*Utah law prohibits insurers from using genetic results for underwriting purposes.

II. INFORMATION FOR APPLICANT AND DEPENDENTS

I understand the following information:

1. I may refuse to sign this authorization, or I may revoke it if I have not been enrolled in SelectHealth by sending my written request to SelectHealth; however, if I do so SelectHealth may refuse to enroll me;
2. A healthcare provider may not condition my treatment on signing this authorization;
3. Another health plan may not condition payment, enrollment, or eligibility for benefits on my signing this authorization;
4. I understand that the information that SelectHealth receives because of this authorization may be redisclosed and no longer protected by federal or state regulation. Items 5 and 6 of this section limit the potential for redisclosure of my information.
5. If SelectHealth does not enroll me, it may not use or disclose the information it receives because of this authorization for any purpose other than underwriting, except as may be required by law (if SelectHealth denies insurance coverage because of an individual's health condition, Utah law requires SelectHealth to tell the applicant specifically what this health condition is);
6. If SelectHealth does enroll me, it will only use information disclosed under this authorization for purposes described in its notice of privacy practices; and
7. Unless revoked, this authorization will remain in effect for underwriting purposes until 60 calendar days from the date SelectHealth has approved or rejected my application.

III. IDENTIFYING INFORMATION/SIGNATURES FOR THE APPLICANT AND DEPENDENTS

Applicant	Date of Birth	Applicant signature	Date Signed
Spouse	Date of Birth	Spouse signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed

*A representative must have legal authority to sign (e.g., a parent/guardian for a minor child). The spouse and any children older than age 18 must sign for themselves.

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

selecthealth℠

Individual Plans Utah Application Supplement Form

January 10

Applicant's Name _____ **Applicant's Social Security# OR Birthdate** _____
(internal use only)

Payment Option ❑ Preauthorized Banking Withdrawal ❑ Online Billing and Payment

(See Payment Selection Form, pg. 3)

A. MEDICAL PLAN INFORMATION

Select one from each of the following: Network, Plan Option, and associated Benefit Section.

Network ❑ select:value ❑ select:med+ ❑ select:care+ — **Select one network.**

Plan Option ❑ HMO/Plus Plan ❑ HealthSave℠ — **Select one plan option and complete associated benefit section below.**

HMO/PLUS BENEFIT SECTION

For HMO/Plus Plan option, complete this section.

BENEFIT AND DEDUCTIBLE

Select one benefit level and one deductible

❑ **Base-Level — Deductible applies to all services first**
- ❑ $250 Medical Deductible ($150 Rx Ded)
- ❑ $500 Medical Deductible ($250 Rx Ded)
- ❑ $1,000 Medical Deductible ($500 Rx Ded)
- ❑ $2,500 Medical Deductible ($1,000 Rx Ded)
- ❑ $5,000 Medical Deductible ($2,000 Rx Ded)
- ❑ $7,500 Medical Deductible ($2,000 Rx Ded)

❑ **Mid-Level — No deductible for office visits**
- ❑ $250 Medical Deductible ($150 Rx Ded)
- ❑ $500 Medical Deductible ($250 Rx Ded)

❑ **High-Level — No deductible for office visits, no deductible for Rx**
- ❑ $250 Medical Deductible
- ❑ $500 Medical Deductible
- ❑ $1,000 Medical Deductible

SUPPLEMENTAL ACCIDENT BENEFIT

First $1,000 per calendar year covered at 100% for accidental injuries. Deductible, copays, and coinsurance apply thereafter.

❑ **Yes, include Supplemental Accident.**

❑ **No, do not include this benefit.**

HEALTHSAVE BENEFIT SECTION

For HealthSave option, complete this section.

DEDUCTIBLE

*Select one deductible under Single **or** Family (Deductible applies to all services **except preventive care**)*

❑ **Single (One person)**
- ❑ **$1,200 Deductible**** (20% coinsurance after deductible with a $3,600 out-of-pocket maximum including deductible)
- ❑ $1,500 Deductible (20% coinsurance after deductible with a $5,000 out-of-pocket maximum including deductible)
- ❑ $2,500 Deductible (20% coinsurance after deductible with a $3,500 out-of-pocket maximum including deductible)
- ❑ $5,000 Deductible (Covered 100% after deductible)

❑ **Family (Two or more)**
- ❑ **$2,400 Deductible**** (20% coinsurance after deductible with a $7,200 out-of-pocket maximum including deductible)
- ❑ $3,000 Deductible (20% coinsurance after deductible with a $10,000 out-of-pocket maximum including deductible)
- ❑ $5,000 Deductible (20% coinsurance after deductible with a $7,000 out-of-pocket maximum including deductible)
- ❑ $10,000 Deductible (Covered 100% after deductible)

****The state of Utah requires all Utah carriers to offer a plan that has the minimum deductible allowed to be federally qualified as an HSA-compatible plan. The deductible is subject to change annually as the federal minimum deductible increases.**

SelectHealth has made a concerted effort to design the HealthSave coverage in compliance with the requirements for a High Deducible 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 VENDOR

SelectHealth's preferred HSA vendor is HealthEquity®. An HSA will be established for you with HealthEquity if you choose 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 also be charged if you choose to terminate the account once it has been established.

❑ **I choose to open an HSA account with HealthEquity.**

❑ **I will use another HSA administrator or not open an HSA at this time.**

B. WAIVER OF DEPENDENT COVERAGE

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

   a) List the reason(s) why any family members are <u>not</u> applying for coverage, and describe their health status and where they are currently covered.

   _____

   _____

2. If you are applying for one-person coverage and have a spouse and/or dependent(s) not included on page 1 of the Individual Universal Application, it is considered a waiver of dependent coverage. Any future dependents (newborn/adopted or otherwise) will not be guaranteed coverage on this plan. To add them to your policy, you will need to submit an application, which will require underwriting approval for a future effective date.

   Please initial here to indicate you understand the waiver of dependent coverage policy. _____
   Applicant Initials

C. SELECTHEALTH DENTAL BENEFIT SECTION

selecthealth® DENTAL

Add Individual/Family Dental Coverage ❑ Yes ❑ No

Applicant(s) must be approved for and enrolled on a SelectHealth individual medical plan to qualify for dental coverage. When selected, dental coverage will be added to all family members on the individual medical plan.

Annual Maximum Benefit *(select one)*	❑ $750	❑ $1,000	❑ $1,500
Individual/Family Deductible	$50/$150	$50/$150	$50/$150
Participating Preventive Coverage	100%	100%	90%
Participating Basic Dental Coverage	80% after deductible	80% after deductible	70% after deductible
Participating Major Dental Coverage	50% after deductible	50% after deductible	50% after deductible
Orthodontia	Not covered	Not covered	Not covered

Have you recently been insured by another dental carrier? ❑ Yes ❑ No

If so, please provide the name of the dental insurance carrier._____

selecthealth℠

Individual Plans Payment Selection Form

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

A. PAYMENT SELECTION

Please select one of the two available methods 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 (we) authorize SelectHealth to initiate debit entries to my (our) ❑ **Checking Account** ❑ **Savings Account**

Account Holder's Name _____ **Account#** _____

Financial Institution _____ **Routing & Transit#** _____

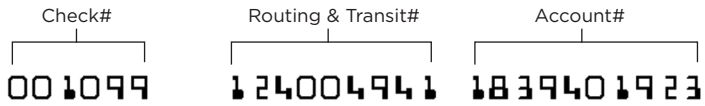
I (we) understand that debit entries will be submitted to my (our) account on or about the 10th of each month regardless of the policy effective date. I (we) understand that a **$25.00 service charge** will be assessed if the premium amount cannot be deducted from my (our) account for any reason.

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.



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 Web site 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 _____

Card Holder's Signature _____

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

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

PO Box 30192
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801-442-5038/800-538-5038
www.selecthealth.org

selecthealth℠

Application Checkoff List

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

- ☐ **Complete and sign the Utah Individual Health Insurance Application Form and Authorization to Disclose Health Information Form**
- ☐ **Read Section I —** Acknowledgement
- ☐ **Complete and sign Individual Plans Supplement Form**
- ☐ **Sign the Payment Selection Form**
- ☐ **Include the first month's premium** (applies to the Online Billing and Payment option)
- ☐ **Attach a voided check for Preauthorized Banking Withdrawal**