selecthealth℠ AN INTERMOUNTAIN HEALTHCARE COMPANY

selecthealth℠ BENEFIT ASSURANCE COMPANY

4646 West Lake Park Boulevard, Salt Lake City, UT 84120-8212 1-801-442-5038/1-800-538-5038 **www.selecthealth.org**

Employee Application (Small Employer Products)

For instructions regarding this application, please refer to section X. "Enrollment Instructions".

I. EMPLOYEE INFORMATION

(Please print using ink)

Last Name ______ First Name ______ Initial ______ Social Security# ______

Street Address ______ Unit# ______ Marital Status ❑ Single ❑ 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:

❑ Birth/Adoption ❑ Marriage ❑ Involuntary Loss of Other Coverage

An Employee Application for a special enrollment event must be submitted within 31 days of the event.

II. PLAN INFORMATION (FILL OUT A, B, C, OR D BELOW BASED ON THE PLAN DESIGN SELECTED BY YOUR EMPLOYER)

A – Open Panel—If your employer has chosen the Open Panel option, select one of the following plan options:
❑ Select Value℠ ❑ Select Med Plus℠ ❑ Select Care Plus℠

B – HealthSave—If your employer has chosen the HealthSave option, select one of the following plan options:
❑ Select Value HealthSave℠* ❑ Select Med Plus℠ HealthSave℠*
❑ Select Care Plus℠ HealthSave℠*

C – Dual Option—If your employer has chosen Dual Option, select one of the following plan options:
❑ HealthSave Plan* ❑ HMO/Plus Plan

D – Select Choice℠ Premier—If your employer has chosen Select Choice Premier, you will be enrolled on this plan.
❑ Select Choice Premier**

*Health Savings Account Administration (HealthSave Plans Only)—If your employer has chosen HealthEquity® (SelectHealth's preferred account vendor), a health savings account will automatically be established for you with HealthEquity, unless you decline this option: ❑ I decline.

II. EMPLOYEE AND DEPENDENT INFORMATION (LIST YOURSELF AND ELIGIBLE DEPENDENT(S) TO BE COVERED BELOW)

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

*REQUIRED FOR HEALTHSAVE PLANS FOR HSA ADMINISTRATION

IV. PRIOR COVERAGE INFORMATION

If you have had health insurance coverage within the last 63 days, your Pre-existing Condition Waiting Period limitation may be credited or waived upon receipt of your Certificate of Creditable Coverage from your prior healthcare plan. To determine if this applies to you, **enclose a copy of the Certificate of Creditable Coverage for each member to be covered** and provide the following information. Failure to provide this information could result in claims being delayed or denied. (Note: A photocopy of your ID Card from your current/previous carrier is not sufficient.)

Policyholder's Name ______ Name of Carrier ______

Policy# ______ Date Coverage Began ______ Date Coverage Ended ______

Submission of prior coverage information does not automatically waive the Pre-existing Condition Waiting Period limitation. However, failure to provide prior coverage information will result in limited or excluded benefits for a 12-month period (18 months for late enrollees).

V. EMPLOYEE SIGNATURE

Employee Signature ______ Date Signed ______

SELECTHEALTH'S USE ONLY

Effective Date ______ Renewal Date ______ NHWP: ❑ 30 ❑ 60 ❑ 90 ❑ Other ______

Group# ______ Sub group# ______ ❑ HSA

PEC waiting period/start date ______

Agent/broker ______ GA ______

VI. HEALTH INFORMATION

INSTRUCTIONS: Answer each question considering each individual applying for medical coverage. **Circle any specific item(s)** in the question that applies. Give complete and specific details in Sections VII and VIII for each "Yes" (Y) answer.

1. Is anyone currently receiving medical treatment .... **Y N**

2. Has anyone consulted, been tested, or had treatment by a doctor, chiropractor, counselor, therapist, or other healthcare provider within the past **THREE YEARS**? .... **Y N**

3. Is any family member currently pregnant, or do they have reason to suspect they might be pregnant?...................... **Y N**

4. Are you or your spouse financially responsible for an unborn child, anticipating adoption, applying for, or have applied for adoption?... **Y N**

5. Do you have any family members who are **not** applying for coverage? If yes, complete **(a)** below .... **Y N**

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

____

____

____

____

____

6. Has anyone ever chewed or smoked tobacco?.................. **Y N**

7. Has anyone taken any medication, drugs, shots, or remedies in the past **TWELVE MONTHS**? If yes, complete Section VIII. .... **Y N**

8. Within the past **FIVE YEARS** has any proposed member:

- **a)** Been advised to be hospitalized, have tests, consultation, evaluation, surgery, or use medication(s) **but has not done so**?........................... **Y N**
- **b)** Been evaluated for fertility, is infertile, or had a miscarriage or complication(s) of pregnancy? .... **Y N**
- **c)** Had gallbladder problems, ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, or other digestive problems? .... **Y N**
- **d)** Had urinary problems or urinary incontinence? .... **Y N**
- **e)** Had irregular bleeding, abnormal Pap smears/tests, pelvic inflammatory disease, endometriosis, prostate or testicular problems, venereal disease, or any disorder of the reproductive system? .... **Y N**
- **f)** Had migraines, been unconscious, or had epilepsy, seizures, or convulsions?... **Y N**
- **g)** Received any mental health counseling, psychotherapy, or had a mental or nervous disorder, depression, stress, or anxiety that required consultation or medication?.... **Y N**
- **h)** Had cysts, growths (except for warts), breast lumps, augmentation, or reduction?...................................... **Y N**
- **i)** Had a skin disorder that required medical attention?.... **Y N**
- **j)** Had a thyroid disorder or a disorder of the lymph nodes or lymph system?... **Y N**
- **k)** Been treated for chest pain, high blood pressure, or high cholesterol?.. **Y N**
- **l)** Had any disorder of the eyes, ears, nose, or throat that required treatment?... **Y N**
- **m)** Had any back, neck, spinal problems, or a joint disorder that required medical attention and/or interfered with normal daily activities?........................ **Y N**
- **n)** Had a problem for which they **have not** sought medical advice or treatment?..................................... **Y N**

9. Within the past **TEN YEARS,** has any proposed member:

- **a)** Been hospitalized or had surgery?.............................. **Y N**
- **b)** Had hepatitis, colitis, a colectomy or ileostomy, rectal disease, spleen problems, jaundice, or other digestive problems?.. **Y N**
- **c)** Had gout, arthritis, fibromyalgia, lupus, any connective tissue disease or disorder, or any joint replacement?.. **Y N**
- **d)** Been diagnosed with, had treatment or surgery for, or any indication of, but not limited to, ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc(s), spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis?............................... **Y N**
- **e)** Had any surgery or treatments for obesity, bulimia, anorexia, weight control, stomach stapling, or gastric bypass?.. **Y N**
- **f)** Had tuberculosis, asthma, sleep apnea, pleurisy, emphysema, or any disorder of the lungs or respiratory system?... **Y N**
- **g)** Been treated for alcohol use or attended Alcoholics Anonymous® for their own alcohol consumption?......... **Y N**
- **h)** Been treated for drug dependency, abuse, or reaction?. **Y N**
- **i)** Been a user of any drug not prescribed, such as: opiates, stimulants, depressants, and/or hallucinogens? . **Y N**

10. Has any proposed member **EVER** had any indication of, diagnosis of, or treatment for:

- **a)** Any birth defect, developmental or learning disability, physical, neurological, neuromuscular, or mental impairment(s)? .... **Y N**
- **b)** Bipolar disorder, manic depression, schizophrenia, chronic organic brain syndrome, or any other organic brain or psychotic disorders?...................................... **Y N**
- **c)** A kidney disorder, liver problems, cirrhosis, or pancreatic problems?.. **Y N**
- **d)** Cancer or tumors? .... **Y N**
- **e)** Diabetes? .... **Y N**
- **f)** Multiple sclerosis, muscular dystrophy, cerebral palsy, or any other neurological disorder?............................. **Y N**
- **g)** Any blood disorder, tested positive for Human Immunodeficiency Virus (HIV), or been treated for or been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any disease or disorder of the immune system?........... **Y N**
- **h)** Any heart condition or problem, heart murmur, heart attack, rapid, slow, or irregular heartbeat, blood clot, stroke, or other circulatory problems?......................... **Y N**

11. Has anyone been unable to work or been unable to perform routine daily functions for more than two weeks (other than for pregnancy)?................................. **Y N**

12. Does anyone have any conditions, symptoms, or problems not otherwise mentioned in connection with answering the above questions? .... **Y N**

13. To your knowledge, has anyone been denied for other health or life insurance or been issued a modified or rated policy?.. **Y N**

14. List the applicant's and the applicant's spouse's height and weight below. List weight as it is now and as it was **ONE YEAR AGO.**

a) Applicant's Height:__________ ft. ________ in.
Applicant's Weight: __________ now;________ one year ago

b) Spouse's Height:__________ ft. ________ in.
Spouse's Weight: __________ now;________ one year ago

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION FORM.

VII. ADDITIONAL INFORMATION (COMPLETE FOR EVERY YES (Y) ANSWER IN SECTION VI)

QUESTION#	FIRST NAME OF INDIVIDUAL	DIAGNOSIS OF ILLNESS INJURY, TREATMENT, TESTING OR MEDICAL ATTENTION	DATE BEGAN (MM/DD/YY)	DATE ENDED (MM/DD/YY)	REMAINING SYMPTOMS OR PROBLEMS	NAME AND PHONE# OF PHYSICIAN OR HOSPITAL

VIII. PRESCRIPTION MEDICATION INFORMATION

FIRST NAME OF INDIVIDUAL	NAME OF MEDICATION	DOSAGE	DATE BEGAN (MM/DD/YY)	DATE ENDED (MM/DD/YY)	REASON FOR MEDICATION	NAME AND PHONE# OF PRESCRIBING PHYSICIAN

IX. 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 Master Group 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 Master Group Contract, benefits will not extend beyond the termination of either my coverage or the Master Group Contract. I represent that all information provided on this Application, including the "Health Information" section, 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 my choice of healthcare providers whose services will be covered may be restricted by the Master Group Contract, and I agree that any services which are obtained without or contrary to required preauthorization/precertification requirements in the Master Group Contract may be denied. I understand the coverage which I am applying for may limit or exclude certain conditions and may exclude conditions for which a family member (including myself) has received any medical diagnosis or treatment or taken any medication or where symptoms were or should have been evident prior to his or her coverage effective date, according to the pre-existing conditions limitation provision of the Master Group Contract. If the Master Group 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, including the health information 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.

X. ENROLLMENT INSTRUCTIONS AND ADDITIONAL INFORMATION

You must read Section IX. "Authorization and Acknowledgment" before signing this Application. It contains policy and terms for agreement. Faxed applications will not be accepted; only original applications will be processed. 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 clearly 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, agent/broker, or an SelectHealth/SelectHealth BAC representative at 1-801-442-4908 Option 2 or 1-800-442-3125 Option 2.

Sections I. and II. – EMPLOYEE INFORMATION AND PLAN 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: In Section I., 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.

** Select Choice Premier is underwritten (insured) by SelectHealth Benefit Assurance Company (SelectHealth BAC) and is administered for SelectHealth BAC by SelectHealth, a separately licensed insurer affiliated with SelectHealth BAC.

Section III. – 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 under the age of 26, unmarried, and dependent upon you for 50 percent of their financial support. (Financial dependency is not required for court or administrative ordered dependent coverage.) 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 medical insurance while this health plan is in force. If you answered yes (Y), indicate the name of the other insurance carrier.

NOTE: You must list other health 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 carrier.

Section IV. – PRIOR COVERAGE INFORMATION

If you and/or your eligible dependent(s) have had health insurance coverage within the last 63 days, your Pre-existing Condition Waiting Period (if applicable) may be credited or waived. You must provide SelectHealth/SelectHealth BAC proof of prior coverage, such as Certificate of Creditable Coverage, for each member. You have the right to request a Certificate of Creditable Coverage from your prior healthcare plan. If necessary, SelectHealth/SelectHealth BAC will assist in obtaining such Certificates.

Section V. – EMPLOYEE SIGNATURE

You must read Section IX. "Authorization and Acknowledgment". If you read, understand, and agree to the terms stated, sign and date this section.

Section VI. – HEALTH INFORMATION

Answer each question for each individual applying for medical coverage. Circle any specific item(s) in the question that apply. For each Y (Yes) answer, **give complete and specific details** in Section VII. and VIII.

Section IX. – AUTHORIZATION AND ACKNOWLEDGMENT

You must read this section. If you read, understand, and agree to the terms stated, sign and date Section V. "Employee Signature."

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