Benefits Manager, Inc

Enrollment Instructions for IHC Health Plans

Here is a checklist of a few things that are commonly overlooked and are mandatory for processing your application.

- ❑ Complete all questions and sections of the application by tabbing to each entry and filling out the requested information.

  Don't forget to -

  - ❑ Enter your required effective date. Remember you must submit to our office by the 25th of the month in order to qualify for your policy to be effective on the 1st of the following month.
  - ❑ Select your preferred billing method.
- ❑ Print two copies of the application one for yourself and one to send to Benefits Manager.
- ❑ Sign and date the application.
- ❑ If you have requested that your monthly premium be deducted automatically from your checking account, you must sign and date the authorization form, attach a voided check to it, and include a check or money order payable to IHC Health Plans for the first month's premium.

Or

- ❑ If you have chosen 6-month prepayment include a check or money order payable to IHC Health Plans for the first six months' premium with the submission of the application.
- ❑ Mail completed, originally signed application and check if applicable to:

  Benefits Manager, Inc
  Attn: New Enrollment
  1235 W. Stone Creek Ln.
  Layton, UT 84041

As an example of one of many of our free services to our clients, Benefits Manager, Inc will review your application for completeness and accuracy before we submit it to IHC Health Plans for approval. This will greatly reduce the approval time because IHC Health Plans does not process unclear or incomplete applications until the missing information has been gathered.

After your application has been reviewed by Benefits Manager it will be submitted to *IHC Health Plans* for processing. If errors are found, please make any necessary charges and re-mail the corrected application to Benefits Manager for processing.

Please contact us if you have any questions regarding the application or enrollment process. You may reach us at (888)310-9623 or e-mail us at mikeoliphant@benefitsmanager.net.

Thank you for giving us this opportunity to serve you. We want to earn the right to have you as one of our Clients for Life.

The Benefits Manager Team

IHC HEALTH PLANS®
IHC® A Service of Intermountain Health Care

PO Box 30192
Salt Lake City, UT 84130-0192
Tel: 1-801-442-3599 or 1-800-660-3599

IHC Personal Managed Care Plans
Application Form

Please use ink and print legibly

Clear Form Entries

I. APPLICANT INFORMATION (Must be oldest family member)

Last Name | First Name | Initial

Street Address | Unit # | Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced

City | State | ZIP

Mailing Address (If different)

Street Address

City | State | ZIP

Your Occupation | Your Spouse's Occupation

E-Mail Address | Home Ph # ( ) | Work Ph # ( )

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

Payment Option ❑ Pre-Authorized Banking Withdrawal ❑ Electronic Billing and Payment (See Payment Selection Form)

Read Me!

II. APPLICANT AND DEPENDENT INFORMATION

IN THE SECTION BELOW, LIST YOURSELF AND ELIGIBLE FAMILY MEMBERS TO BE INCLUDED UNDER MEDICAL COVERAGE.

Relationship	Name (First, Middle Initial, Last)	Social Security # (For Internal Use Only)	Sex	Birth Date (MM/DD/YY)	Age
Self					
Spouse[1]					
Child[2]					
Child[2]					
Child[2]					
Child[2]					

1. If you are **adding your spouse**, he or she may only be deleted from your coverage under the following circumstances:
   - When your spouse agrees to be deleted from coverage by signing a Personal Plan's 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).
2. 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.

Read Me!

III. DUAL COVERAGE/COORDINATION OF BENEFITS INFORMATION

For Dual Coverage/Coordination of Benefit purposes, indicate each individual who will also be covered by other medical insurance **while coverage with IHC is in force.** Please do not complete this section if other coverage will be terminated once the IHC health plan is in force.

Relationship	Name of Individuals Covered by other insurance	Carrier Name	Carrier Ph #	Policy Number	Effective Date

IHC HEALTH PLANS' USE ONLY

Class #	**Plan**	**Agent/Broker** Michael D. Oliphant	**Agent/Broker #**
Effective Date		**Rate Adjustment Percent**	**Monthly Payment $**
PEC Start Date		**PEC Credit**	
HPI Notes		**HSA** ❑ Yes ❑ No	

If you need additional space, please use another application form.

IV. PLAN INFORMATION

SELECT ONE FROM EACH OF THE FOLLOWING: Network, Plan Option, and associated Benefit Section

IHC MED℠ — A Product of IHC Health Plans

SELECTMED℠ — A Product of IHC Health Plans

IHC CARE℠ — A Product of IHC Health Plans

NETWORK ❑ IHC Med℠ ❑ SelectMed℠ ❑ IHC Care℠ — **Select one network**

PLAN OPTION ❑ HMO Plans ❑ HealthSave℠ — **Select one plan option and complete associated Benefit Section below**

IF you are selecting an HMO Plan, complete the HMO Benefit Section.
IF you are selecting the HealthSave option, complete the HealthSave Benefit Section.

HMO Benefit Section

Only for HMO — **Read Me!**

BENEFIT AND DEDUCTIBLE ***Select benefit level (Base, Mid, or High) and deductible***

❑ **Base-Level Plan**
Deductible applies to all services first
- ❑ $250 Medical Ded ($100 Rx Ded)
- ❑ $500 Medical Ded ($200 Rx Ded)
- ❑ $1,000 Medical Ded ($400 Rx Ded)
- ❑ $2,500 Medical Ded ($1,000 Rx Ded)

❑ **Mid-Level Plan**
No deductible for office visits, with deductible for Rx
- ❑ $250 Medical Ded ($100 Rx Ded)
- ❑ $500 Medical Ded ($200 Rx Ded)

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

COINSURANCE/COPAY ***Select one coinsurance and copay amount***
❑ 70/30–$25/35 ❑ 80/20–$15/25

HealthSave Benefit Section

Only for HealthSave

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

❑ **Single (One person)**
- ❑ $1,500 Deductible (You pay 20% coinsurance after deductible)
- ❑ $2,700 Deductible (You pay 20% coinsurance after deductible)
- ❑ $5,000 Deductible (Covered 100% after deductible)

❑ **Family (Two or more)**
- ❑ $3,000 Deductible (You pay 20% coinsurance after deductible)
- ❑ $5,400 Deductible (You pay 20% coinsurance after deductible)
- ❑ $10,000 Deductible (Covered 100% after deductible)

❑ **Are you electing to use IHC Health Plans' preferred HSA vendor? (Selected HSA Vendor)**
❑ Yes ❑ No

Note: An administrative fee of $3.50 per month is included in your premium amount, regardless of whether you choose to use the preferred HSA vendor.

You may choose to use this option with a Health Savings Account (HSA). IHC Health Plans has made a concerted effort to design the coverage in compliance with the requirements for a High Deducible Health Plan (HDHP) under federal law (Section 223 of the Internal Revenue Code).

However, IHC Health Plans makes no representations or warranties about the legal adequacy of this coverage as an HSA compatible plan. IHC Health Plans 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.

IHC HEALTH PLANS®
IHC® A Service of Intermountain Health Care

PO Box 30192
Salt Lake City, UT 84130-0192
Tel: 1-801-442-3599 or 1-800-660-3599

Authorization to Disclose Health Information to IHC Health Plans for Pre-Enrollment Underwriting Purposes

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

I. Identifying Information for the Applicant and Dependents

Applicant			Date of Birth
Spouse			Date of Birth
Child			Date of Birth
Child			Date of Birth
Child			Date of Birth
Child			Date of Birth
Child			Date of Birth
Current Address	City	State	Zip
Phone Number			

II. Authorization

I authorize any health plan and any health care provider (including any pharmacy) to disclose medical information about me to IHC Health Plans for purposes of determining my eligibility for health insurance coverage as requested in the application dated October 28, 2005 ("My Application"). 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 test results for underwriting purposes.

III. 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 IHC Health Plans by sending my written request to the address above; however, if I do so IHC Health Plans may refuse to enroll me;
2. A health care provider may not condition my treatment on my 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 IHC Health Plans 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 IHC Health Plans 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 IHC Health Plans denies insurance coverage because of an individual's health condition, Utah law requires IHC Health Plans to tell the applicant specifically what this health condition is);
6. If IHC Health Plans does enroll me, it will only use information disclosed to it under this Authorization for purposes described in its notice of privacy practices;
7. Unless revoked, this Authorization will remain in effect until the earlier of:
   a. The date that IHC Health Plans has rejected My Application for insurance; or
   b. 60 calendar days from the date of my application.

IV. Signatures

Applicant	If signed by representative, legal authority#	Date October 28, 2005
Spouse	If signed by representative, legal authority#	Date October 28, 2005
Child	If signed by representative, legal authority#	Date October 28, 2005
Child	If signed by representative, legal authority#	Date October 28, 2005
Child	If signed by representative, legal authority#	Date October 28, 2005
Child	If signed by representative, legal authority#	Date October 28, 2005
Child	If signed by representative, legal authority#	Date October 28, 2005

#A representative must have legal authority to sign (e.g., a parent/guardian for a minor child). Generally, a spouse and children over 18 years of age must sign for themselves.

V. HEALTH INFORMATION

Read Me!

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 VI and VII 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 health care 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 VII. . . . . 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? . . . . 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 problem? . . . . . 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.

VI. ADDITIONAL INFORMATION

Read Me!

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

VII. PRESCRIPTION MEDICATION INFORMATION

Read Me!

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

VIII. GENERAL INFORMATION

Read Me!

1. Is any employer reimbursing or paying for any portion of this plan? . . . . . Y N
2. Are you self-employed? . . . . . Y N
   2a. If self-employed, do you have any full- or part-time employees? . . . . . Y N
3. Does any listed proposed member live, reside, work, or attend school outside the state of Utah at any time during the year? . . . . . Y N

Please explain "yes" answers to the above questions: _____

IX. PRIOR COVERAGE INFORMATION

Read Me!

Have you had health insurance coverage within the past 63 days? . . . . . ❑ Yes ❑ No If "Yes," list carrier information below.

If you answered "No," when was the last date you were insured? _____

Have you EVER been covered under IHC Health Plans . . . . . ❑ Yes ❑ No

If "Yes," list Policy #: _____ **and Policyholder's Name:** _____

If you have had continuous health care coverage not separated by a break in coverage of 63 days or more, your Pre-Existing Condition Waiting Period limitation may be partially or completely waived. To determine if this applies to you, **you must enclose proof of prior coverage**. This could include the following: Certificate of Creditable Coverage from your previous carrier; an Explanation of Benefits (EOB) or other correspondence from a plan or issuer indicating coverage; pay stubs showing payroll deduction for health coverage; a health insurance ID Card; a certificate of coverage under a group health policy; records from medical care providers indicating health coverage; third-party statements verifying periods of coverage; any other relevant documents that evidence periods of health coverage; or a telephone call from the Plan or provider to the Plan verifying Creditable Coverage. **You must also provide the following information:**

Policyholder's Name _____ Name of Carrier _____

Policy Number _____ Effective Date _____ Termination Date _____

Carrier's Address _____ Carrier's Phone Number _____

If you were previously insured on a group plan, have you exhausted your COBRA rights? . . . . . ❑ Yes ❑ No ❑ Not Available

(COBRA rights are your rights to continue coverage for 18 to 36 months after terminating employment.)

If "Yes," please list dates: Date Started _____ Date Ended _____

If COBRA was not an option for you, have you exhausted your Utah mini-COBRA rights? . . . . . ❑ Yes ❑ No ❑ Not Available

(Utah mini-COBRA rights are your rights to continue group health coverage.)

If "Yes," please list dates: Date Started _____ Date Ended _____

Have you ever been or are you currently insured through the Utah Comprehensive Health Insurance Pool (HIPUtah)? . . . ❑ Yes ❑ No

If "Yes," please list dates: Date Started _____ Date 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 an automatic 12-month Pre-existing Condition Waiting Period.

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

X. AUTHORIZATION AND ACKNOWLEDGMENT

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with IHC Health Plans, Inc. When incorporated with the Contract, this Application and the Member Payment Summary become part of the Contract. Once fully signed and executed, Plan and I agree to terms set forth in the Contract. 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 spouse and other dependents. Further, in dealing with IHC Health Plans, 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 by IHC Health Plans, that no benefits will be provided for any services which begin before the coverage is effective, and that except as expressly provided in the Contract, benefits will not extend beyond the termination of either my coverage or the Contract.

CONSENT AT ENROLLMENT. I understand that no agent or Plan representative is allowed to permit me to answer any questions inaccurately, untruthful, or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to the Plan changes in the eligibility of any applicants who become members.

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 Contract, and I agree that any services which are obtained without or contrary to required preauthorization/precertification requirements in the Contract may be denied coverage. I understand the coverage for which I am applying 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 provisions of the Contract. I understand that this Application will become part of the Contract.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE. According to information you have furnished, you may intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by IHC Health Plans, Inc. Your new policy provides ten days within which you may decide without cost whether you desire to keep the plan. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new plan.

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 plan, whereas a similar claim might have been payable under your present policy or plan.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest 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 or health history.
4. Failure to include all material medical information on an application may provide a basis for the Plan to deny any future claims and to refund your premium as though your plan 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 two and three 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 IHC Health Plans.

XI. SIGNATURE OF APPLICANT AND SPOUSE

Signature Applicant Sign and Date Here Date Signed October 28, 2005

Spouse's Signature
(Required if applying for coverage) Date Signed October 28, 2005

XII. AGENT/BROKER AGREEMENT (IF APPLICABLE)

I understand and agree that in acting as the agent/broker 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 IHC Health Plans, Inc., or **b)** waive any of the terms of conditions of the Contract.
4. I have no authority to assign effective dates or to affect membership changes.
5. Cancellation of this Health Care Agreement by either the subscriber or IHC Health Plans, Inc. will terminate this Agency Agreement.

Date application received at IHC Health Plans, Inc.

Agent/
Broker Name Michael D. Oliphant Agency PH# (888) 310-9623

Agent Signature Agent/Broker Sign and Date Here Date Signed October 28, 2005

Requested Effective Date_____
Coverage is not in force until your application is approved and an effective date is determined by IHC Health Plans, Inc.

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

IHC HEALTH PLANS®
IHC® A Service of Intermountain Health Care

PO Box 30192
Salt Lake City, UT 84130-0192
Tel: 1-801-442-3599 or 1-800-660-3599

IHC Personal Managed Care Plans
Payment Selection Form

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

A. PAYMENT SELECTION

Read Me!

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.

❑ **Pre-Authorized Banking Withdrawal**
(Complete Section B)

❑ **Electronic Billing and Payment**
(Complete Section C. You must include a check for the first month's premium)

B. PRE-AUTHORIZED BANKING WITHDRAWAL

Read Me!

If you select this method of payment for your monthly premium, your payment will automatically be deducted from your checking/savings account each month. Please complete the information below.

I (we) authorize IHC Health Plans, Inc. to initiate debit entries to my (our): ❑ **Checking Account** ❑ **Savings Account**

Account Holder's Name | **Account Number**

Financial Institution | **Routing and Transit Number**

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.

October 28, 2005

Account Holder's Signature | **Date**

Pre-Authorized 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. ELECTRONIC BILLING AND PAYMENT

If you have selected the Electronic 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 an Internet 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, using a check or credit card with your application. Premium payments are due on the first dayof each month.

Applicant's Signature | **Applicant's Phone #**

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

Print Form

1500/3000 PLAN

HEALTHSAVE PREMIUM RATES

Deductible applies to all services except preventive care.

IHC MED HEALTHSAVE

Deductible $1,500/$3,000

Age	Single	2-Party	Family
0 - 19	53	86	132
20 - 24	56	97	142
25 - 29	64	110	175
30 - 34	72	125	212
35 - 39	78	127	242
40 - 44	89	149	282
45 - 49	102	177	318
50 - 54	117	209	336
55 - 59	139	256	367
60 - 64	168	315	427

SELECTMED HEALTHSAVE

Deductible $1,500/$3,000

Age	Single	2-Party	Family
0 - 19	57	93	143
20 - 24	60	105	154
25 - 29	69	119	190
30 - 34	78	135	230
35 - 39	84	138	263
40 - 44	96	162	307
45 - 49	111	192	346
50 - 54	127	227	365
55 - 59	151	278	399
60 - 64	183	342	464

IHC CARE HEALTHSAVE

Deductible $1,500/$3,000

Age	Single	2-Party	Family
0 - 19	65	107	164
20 - 24	69	120	176
25 - 29	79	136	218
30 - 34	90	155	264
35 - 39	96	158	302
40 - 44	110	185	352
45 - 49	127	220	397
50 - 54	145	260	420
55 - 59	173	319	458
60 - 64	210	393	533

2700/5400 PLAN

HEALTHSAVE PREMIUM RATES

Deductible applies to all services except preventive care.

IHC MED HEALTHSAVE

Deductible		$2,700/$5,400	
Age	Single	2-Party	Family
0 - 19	49	78	124
20 - 24	52	88	133
25 - 29	59	100	164
30 - 34	67	113	199
35 - 39	72	115	227
40 - 44	82	135	265
45 - 49	95	160	298
50 - 54	108	190	315
55 - 59	129	232	344
60 - 64	156	286	400

SELECTMED HEALTHSAVE

Deductible		$2,700/$5,400	
Age	Single	2-Party	Family
0 - 19	53	85	134
20 - 24	56	95	144
25 - 29	64	108	178
30 - 34	73	123	216
35 - 39	78	125	246
40 - 44	89	147	287
45 - 49	103	174	324
50 - 54	118	206	342
55 - 59	139	252	373
60 - 64	169	310	435

IHC CARE HEALTHSAVE

Deductible		$2,700/$5,400	
Age	Single	2-Party	Family
0 - 19	60	97	154
20 - 24	64	109	165
25 - 29	73	124	204
30 - 34	83	141	248
35 - 39	89	143	283
40 - 44	102	168	330
45 - 49	118	199	372
50 - 54	135	236	393
55 - 59	160	289	429
60 - 64	194	356	500

5000/10000 PLAN

HEALTHSAVE PREMIUM RATES

Deductible applies to all services except preventive care.

IHC MED HEALTHSAVE

Deductible		$5,000/$10,000	
Age	Single	2-Party	Family
0 - 19	43	65	115
20 - 24	45	73	123
25 - 29	52	83	152
30 - 34	59	94	184
35 - 39	63	96	210
40 - 44	72	112	245
45 - 49	83	133	276
50 - 54	95	157	291
55 - 59	112	192	318
60 - 64	136	236	370

SELECTMED HEALTHSAVE

Deductible		$5,000/$10,000	
Age	Single	2-Party	Family
0 - 19	47	70	124
20 - 24	49	79	133
25 - 29	56	90	165
30 - 34	64	102	200
35 - 39	69	104	228
40 - 44	78	122	266
45 - 49	90	144	300
50 - 54	103	170	316
55 - 59	122	208	345
60 - 64	148	257	402

IHC CARE HEALTHSAVE

Deductible		$5,000/$10,000	
Age	Single	2-Party	Family
0 - 19	53	81	143
20 - 24	56	91	153
25 - 29	64	103	189
30 - 34	73	117	229
35 - 39	78	119	261
40 - 44	89	139	305
45 - 49	103	165	344
50 - 54	118	195	363
55 - 59	140	239	396
60 - 64	169	294	462

HEALTHSAVE BENEFIT SUMMARY

This table is for comparison purposes only and does not replace the Member Payment Summary. Please refer to the Contract and Member Payment Summary for detailed benefit information.

BENEFITS	HealthSave – 1500/3000 or 2700/5400	HealthSave – 5000/10000
Lifetime Maximum Plan Payment	None	None
Pre-Existing Conditions	Not covered for first 12 months[1]	Not covered for first 12 months[1]
Deductibles Deductible is included in the Out-of-Pocket Maximum	$1,500 (Single) / $3,000 (Family) **or** $2,700 (Single) / $5,400 (Family)	$5,000 (Single) $10,000 (Family)
Out-of-Pocket Maximums	$5,000 (Single) $10,000 (Family)	$5,000 (Single) $10,000 (Family)
Office Visit Copay Primary Care Provider (PCP) Secondary Care Provider (SCP)	PCP – You pay $15 after deductible[2] SCP – You pay $25 after deductible[2]	Covered 100% after deductible[2]
Emergency Room Visit Participating (Par) Nonparticipating (Nonpar)	Par – You pay $100 after deductible Nonpar – You pay $200 after deductible	Covered 100% after deductible
Prescription Drugs *Up to a 30-day supply for covered medications; generic substitution required; same copay/coinsurance applies to 90-day maintenance home delivery supply.*	Tier I: You pay $5 after deductible Tier II: You pay 25% after deductible Tier III: You pay 50% after deductible	Covered 100% after deductible
Coinsurance Includes: Inpatient services, outpatient services, physicians fees, ambulance, chemotherapy, radiation, dialysis, home health, durable medical equipment, injectable drugs, allergy treatment, major diagnostic tests, miscellaneous medical supplies.	You pay 20% after deductible *Limit for inpatient skilled nursing facility is 60 days per calendar year. Limit for inpatient rehab therapy is 40 days per calendar year.*	Covered 100% after deductible *Limit for inpatient skilled nursing facility is 60 days per calendar year. Limit for inpatient rehab therapy is 40 days per calendar year.*
IHC InstaCare/Urgent Care Facility	You pay $25 after deductible	Covered 100% after deductible
IHC KidsCare Facility	You pay $15 after deductible	Covered 100% after deductible
Immunizations	Covered at 100%	Covered at 100%
Minor Diagnostic Tests	Covered 100% after deductible[2]	Covered 100% after deductible[2]
Infertility	You pay 50% after deductible Maximum plan payment is $1,500 per calendar year; $5,000 lifetime	Covered 100% after deductible Maximum plan payment is $1,500 per calendar year; $5,000 lifetime
Outpatient Rehab Therapy *Visit limit for outpatient rehab therapy is 20 per calendar year..*	You pay $25 after deductible	Covered 100% after deductible
Mental Health	You pay 50% after deductible Day limit for inpatient is 10 per calendar year Visit limit for outpatient is 15 per calendar year	Covered 100% after deductible Day limit for inpatient is 10 per calendar year Visit limit for outpatient is 15 per calendar year
Maternity & Adoption	Not covered	Not covered
Chiropractic	Not covered	Not covered
Supplemental Accident	Not available	Not available

FOOTNOTES

1. Waived (entirely or partially) for qualifying pre-existing condition credit

2. Benefits for preventive care services are paid before deductible is met; You pay $15/$25 copay