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.

- ❑ Print all pages of the application including instructions.
- ❑ Complete all questions and sections of the application in blue or black ink.

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.
- ❑ 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 and attach a voided check to it.

Or

- ❑ If you have chosen the Electronic Billing and Payment option, you must include a check or money order payable to IHC Health Plans for the first month's premium and your e-mail address with 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

I. APPLICANT INFORMATION

Social Security # (For Internal Use Only) | Last Name | First Name | Initial

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

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

II. PLAN AND PAYMENT INFORMATION

SELECT ONE FROM EACH OF THE FOLLOWING (Plan Option, Benefit Selection, Payment Option):

PLAN OPTIONS ❑ IHC Med ❑ SelectMed ❑ IHC Care

BENEFIT SELECTION ***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 (No Rx Ded)
- ❑ $500 Medical Ded (No Rx Ded)
- ❑ $1,000 Medical Ded (No Rx Ded)

III. APPLICANT AND DEPENDENT INFORMATION

LIST YOURSELF AND ELIGIBLE FAMILY MEMBERS TO BE INCLUDED UNDER MEDICAL COVERAGE BELOW:

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.

IV. 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

V. 24-HOUR COVERAGE INFORMATION

24-Hour Coverage . . . . ❑ **Yes** ❑ **No** If yes, list the name of each individual to be covered under 24-Hour Coverage. **Note**: 24-Hour Coverage is for those who are not required by law to be covered under workers' compensation insurance. There is an additional cost of $25.00 per month for each person with 24-Hour Coverage. This coverage is subject to underwriting approval.

1. | **2.**

Class # | **Plan** | **Agent/Broker** | **Agent/Broker #**

Effective Date | **Rate Adjustment Percent** | **Monthly Payment $**

PEC Start Date | **PEC Credit**

HPI Notes

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

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VI. HEALTH INFORMATION

INSTRUCTIONS: Answer each question for each individual applying for medical coverage. **Circle any specific item(s)** in the question that applies. Give complete and specific details in Sections VIII and IX 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. Does anyone have a problem for which they have not sought medical advice or treatment? Y N
6. 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.

____
____
____
____
____
____

7. Has anyone ever chewed or smoked tobacco? Y N
8. Has anyone taken any medication, drugs, shots, or remedies in the past **twelve months**? If yes, complete Section VIII. Y N

9. **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, 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

10. **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

11. **Has any person proposed for coverage 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

12. 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
13. Does anyone have any conditions, symptoms, or problems not otherwise mentioned in connection with answering the above questions? Y N
14. Has anyone been denied for other health or life insurance or been issued a modified or rated policy? Y N
15. 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

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

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VII. ADDITIONAL INFORMATION

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. GENERAL INFORMATION

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: ______

X. PRIOR COVERAGE INFORMATION

Do you currently have health insurance coverage? . . . . ❑ 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 within the last 90 days, 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 State Continuation rights? . . . . ❑ Yes ❑ No ❑ Not Available

(State Continuation 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 State Health Insurance Pool (HIP)? . . . . ❑ 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.

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XI. 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 materials 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.

XII. SIGNATURE OF APPLICANT AND SPOUSE

Signature Applicant Sign and Date Here Date Signed

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

XIII. 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 effect 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 Agency PH#

Agent/Broker Sign and Date Here

Agent Signature Date Signed

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.

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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

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.

- ❑ **Pre-Authorized Banking Withdrawal** *(Complete Section B)*
- ❑ **Electronic Billing and Payment** *(Complete Section C. You must include a check for first month's premium)*

B. PRE-AUTHORIZED BANKING WITHDRAWAL

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.

Account Holder's Signature | **Date**

Applicant's Name | **Applicant's Social Security #**

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 with your application. Premium payments are due on the first day of each month.

Applicant's Name | **Applicant's Signature**

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

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