

Employee Application Small Employer

For instructions regarding this application, please refer to section J. "Enrollment Instructions" on page 4.

A. EMPLOYEE INFORMATION (PLEASE USE DARK INK AND PRINT LEGIBLY)

 Last Name _____ First Name _____ Initial _____ Social Security# _____
 Street Address _____ Unit# _____ Status Single Legally 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 Utah Premium Partnership

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

B. PLAN INFORMATION (COMPLETE SECTIONS 1, 2, 3, OR 4 BELOW BASED ON THE PLAN DESIGN SELECTED BY YOUR EMPLOYER)

1 - Open Panel—If your employer has chosen the Open Panel option, select one of the following plan options:
 Select ValueSM Select Med PlusSM Select Care PlusSM
3 - Dual Option—If your employer has chosen Dual Option, select one of the following plan options:
 HMO/Plus Plan HealthSave Plan* (see HSA section below)

2 - HealthSave—If your employer has chosen the HealthSave option, select one of the following plan options:
 Select Value HealthSave^{SM*} Select Med Plus HealthSave^{SM*}
 Select Care Plus HealthSave^{SM*} (see HSA section below)

4 - Select ChoiceSM Premier—If your employer has chosen Select Choice Premier, you will be enrolled on this plan.
 Select Choice Premier (see ** in section J.)

*Health Savings Account (HSA) (HealthSave Plans Only)—If your employer has chosen HealthEquity® (SelectHealth's preferred account vendor), **check one** Yes, set up my HSA with HealthEquity No, do not set up an HSA account for me
If you check yes, you must also complete the *HSA Enrollment and Authorization to Disclose Health Information to HealthEquity Form*.

C. 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 OTHER INS. 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

D. 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 information requested below. 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).

E. EMPLOYEE SIGNATURE

Employee Signature _____ Date Signed _____/_____/_____

SELECTHEALTH USE ONLY

 Effective Date _____ Renewal Date _____ NHWP 1 2 3 Other _____

 Group# _____ Sub group# _____ HSA

PEC waiting period/start date _____

Agent/broker _____ GA _____

F. 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 G. and H. 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 H..... **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.

I. 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 the Master Group Contract may limit the healthcare providers whose services will be covered. I understand that the Master Group Contract limits or excludes certain conditions or services and that pre-existing conditions applicable to myself or others included on this Application may not be covered. I agree that to the extent I do not abide by the terms of the Master Group Contract, healthcare services I obtain may not be covered. 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.

J. MEDICAL ENROLLMENT INSTRUCTIONS AND ADDITIONAL INFORMATION

You must read Section I. "Authorization and Acknowledgment" before signing this application. It contains policy and terms for agreement. 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 legibly 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 **801-442-4908, option 2 or 800-442-3125, option 2.**

Sections A. and B. - 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 A., 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 C. - 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 younger than age 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 D. - 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 E. - EMPLOYEE SIGNATURE

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

Section F. - 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 sections G. and H.

Section I. - AUTHORIZATION AND ACKNOWLEDGMENT

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