

January
10

Individual Plans Reapplication Form

This form can be used to reapply for coverage only for members currently listed on your policy. If you wish to add dependents not currently on your policy, please submit a full Individual Plans Application form which includes a complete medical history. Those who reapply will be medically underwritten, and if your request for plan change is denied, or if you do not wish to accept the new offer, you will be able to retain your current coverage without interruption.

Reapplication is only available to subscribers who have been on their current plan for two consecutive years or more.

A. SUBSCRIBER INFORMATION

Subscriber's Name _____ Subscriber ID _____ Date of Birth _____
(LOCATED ON ID CARD)

Address _____ Unit/Apt.# _____

City _____ State _____ ZIP _____ New Ph# (____) _____

E-mail Address _____

B. HEALTH INFORMATION

Please list the current height and weight for the following members on your plan in the boxes provided below.

	FIRST NAME	HEIGHT		WEIGHT (LBS)
Subscriber		ft.	in.	
Spouse		ft.	in.	

Instructions: Answer each question considering each individual currently on your policy. If the answer to either of these questions is "yes," please explain in the boxes provided below.

- Yes No Are you, or any dependent to be covered, currently pregnant, or have reason to suspect you might be pregnant?
- Yes No In the past 12 months, have you, or any dependent to be covered, been recommended to have, or been scheduled for, diagnostic testing, treatment, or surgery **that has not been completed?**

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

C. AUTHORIZATION AND ACKNOWLEDGMENT

I am applying for a change to my coverage with SelectHealth along with the dependents listed on my current policy, if applicable. Once fully signed and executed, SelectHealth and I agree to the terms set forth in the Contract, which shall include this application and the Member Payment Summary. I agree that I am and will act as agent and/or as natural guardian for my spouse and other dependents in dealing with SelectHealth. I understand that the coverage I am applying for shall be extended only if I satisfy SelectHealth's underwriting criteria. I also understand that unless expressly provided in the Contract, benefits will not extend beyond the termination of either my coverage or the Contract.

The information that I have presented in this application is true and complete. I understand that I have a continuing responsibility to report to SelectHealth eligibility changes for myself or any dependents on my policy.

I understand that the Contract may limit my choice of healthcare providers and the services they provide, and I agree that to the extent I do not abide by the terms of the Contract, healthcare services I obtain may be denied.

I hereby declare that to the best of my knowledge and belief, the information given on this application is 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 SelectHealth.

Signature _____ **Date Signed** _____

Spouse's Signature _____ **Date Signed** _____

SELECTHEALTH USE ONLY

Class# _____ **Plan** _____ **Effective Date** _____ **HSA** Yes No

Agent/Broker _____ **Agent/Broker#** _____

Rate Adjustment Percent _____ **Monthly Payment \$** _____ **PEC Start Date** _____

Notes

D. PLAN INFORMATION

SELECT ONE FROM EACH OF THE FOLLOWING: NETWORK, PLAN OPTION, AND ASSOCIATED BENEFIT SECTION

▶ **Network** Select Value® Select Med Plus® Select Care PlusSM ◀ **Select one network**

▶ **Plan Option** HMO/Plus Plan HealthSaveSM ◀ **Select one plan option and complete associated benefit section below**

For HMO/Plus Plan option, complete this section.

BENEFIT AND DEDUCTIBLE

Select one benefit level and one deductible

- Base-Level — Deductible applies to all services first**
 - \$250 Medical Deductible (\$150 Rx Ded)
 - \$500 Medical Deductible (\$250 Rx Ded)
 - \$1,000 Medical Deductible (\$500 Rx Ded)
 - \$2,500 Medical Deductible (\$1,000 Rx Ded)
 - \$5,000 Medical Deductible (\$2,000 Rx Ded)
 - \$7,500 Medical Deductible (\$2,000 Rx Ded)
- Mid-Level — No deductible for office visits**
 - \$250 Medical Deductible (\$150 Rx Ded)
 - \$500 Medical Deductible (\$250 Rx Ded)
- High-Level — No deductible for office visits, no deductible for Rx**
 - \$250 Medical Deductible
 - \$500 Medical Deductible
 - \$1,000 Medical Deductible

SUPPLEMENTAL ACCIDENT BENEFIT

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

- Yes, include Supplemental Accident.**
- No, do not include this benefit.**

For HealthSave option, complete this section.

DEDUCTIBLE

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

- Single (One person)**
 - \$1,200 Deductible*** (20% coinsurance / \$3,600 out-of-pocket maximum)
 - \$1,500 Deductible (20% coinsurance / \$5,000 out-of-pocket maximum)
 - \$2,500 Deductible (20% coinsurance / \$3,500 out-of-pocket maximum)
 - \$5,000 Deductible (Covered 100% after deductible)
- Family (Two or more)**
 - \$2,400 Deductible*** (20% coinsurance / \$7,200 out-of-pocket maximum)
 - \$3,000 Deductible (20% coinsurance / \$10,000 out-of-pocket maximum)
 - \$5,000 Deductible (20% coinsurance / \$7,000 out-of-pocket maximum)
 - \$10,000 Deductible (Covered 100% after deductible)

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

SelectHealth has made a concerted effort to design the HealthSave coverage in compliance with the requirements for a High Deductible Health Plan (HDHP) under federal law (Section 223 of the Internal Revenue Code). However, SelectHealth makes no representations or warranties about the legal adequacy of this coverage as an HSA-compatible plan. SelectHealth is not responsible for any issues relating to your use of the coverage in conjunction with an HSA including, without limitation, your compliance with the requirements of the Internal Revenue Code.

HEALTH SAVINGS ACCOUNT VENDOR

An HSA will be established for you with HealthEquity® if you choose this option (see check box below). An administrative fee is included in your premium amount, regardless of whether you choose to use the preferred HSA vendor.

- I choose to open an HSA account with HealthEquity.**
- I will use another HSA administrator or not open an HSA at this time.**

E. AGENT/BROKER AGREEMENT (IF APPLICABLE)

I understand and agree that in acting as the agent/broker for this applicant that the application was completed by the applicant. I am in possession of a valid license issued by the state of Utah that authorizes me to sell and service health insurance contracts. I have no authority to: a) make, alter, interpret, or discharge an application or contract in the name of SelectHealth, or b) waive any of the terms of conditions of the Contract. I have no authority to assign effective dates or to affect member changes. Cancellation of this Healthcare Agreement by either the subscriber or SelectHealth will terminate this Agency Agreement.

Agent/Broker Name _____ **Agency** _____ **Ph#()** _____

Agent Signature _____ **Date Signed** _____