

Application Guide

Please consider the following when choosing between HIPUtah and Federal-HIPUtah:



HIPUtah Traditional Coverage Options

\$500 Deductible/\$2,000 Out-of-Pocket Maximum
 \$1,000 Deductible/\$3,000 Out-of-Pocket Maximum

Traditional Rx Benefits

- Separate Rx deductible applies.
- There is no Rx out-of-pocket maximum.

HIPUtah HDHP Coverage Options

\$2,500 Deductible (HDHP)/\$4,000 Out-of-Pocket Maximum
 \$5,000 Deductible (HDHP)/\$5,000 Out-Of Pocket Maximum

HDHP Rx Benefits

- Combined medical and Rx deductible.
- Combined medical and Rx out-of-pocket maximum.

Prior Coverage

- You may apply for this plan if you are uninsured for any duration.
- Pre-existing conditions may be excluded for the first six months of this plan (maternity is excluded for the first ten months).

Effective Date

- You may request your desired effective date. SelectHealth reserves the right to make the final effective date determination.



Federal HIPUtah Traditional Coverage Options

\$500 Deductible/\$2,000 Out-of-Pocket Maximum
 \$1,000 Deductible/\$3,000 Out-of-Pocket Maximum

Traditional Rx Benefits

- Separate Rx deductible applies.
- There is a separate Rx out-of-pocket maximum.

Federal HIPUtah HDHP Coverage Options

\$2,500 Deductible (HDHP)/\$4,000 Out-of-Pocket Maximum
 \$5,000 Deductible (HDHP)/\$5,000 Out-Of Pocket Maximum

HDHP Rx Benefits

- Combined medical and Rx deductible.
- Combined medical and Rx out-of-pocket maximum.

Prior Coverage

- You may apply for this plan if you are uninsured for six months or more.
- Pre-existing condition exclusions do not apply to this plan.

Effective Date

- You may request your desired effective date. SelectHealth reserves the right to make the final effective date determination.



New Enrollee Application Form

Please use dark ink and print legibly. Do not write in shaded areas.

Administered by SelectHealth

A. COVERAGE AND PAYMENT INFORMATION

Plan Type	Coverage	Payment Option
<i>Select one plan type.</i> <i>Refer to the Application Guide for more information.</i>	<i>Select one deductible</i>	
<input type="checkbox"/> HIPUtah <input type="checkbox"/> 18 and younger applying for certificate of insurability <input type="checkbox"/> Federal-HIPUtah	<input type="checkbox"/> \$500 Deductible <input type="checkbox"/> \$1,000 Deductible <input type="checkbox"/> \$2,500 Deductible <input type="checkbox"/> \$5,000 Deductible	<input type="checkbox"/> Direct Monthly Billing (\$5.00 monthly service fee applies. This option is not available on Federal-HIPUtah plans) <input type="checkbox"/> Preauthorized Banking Withdrawal <input type="checkbox"/> Online Billing and Payment (See Payment Selection Form)
Desired Effective Date _____ / _____ / _____		

B. APPLICANT INFORMATION

Note: Every person applying for a policy must complete a separate application, including members of the same family.

Applicant

Last Name _____ First Name _____ Middle Initial _____
Social Security# _____ Date of Birth _____ / _____ / _____ Sex M F
Street Address _____ Unit# _____
City _____ State _____ ZIP _____
Mailing Address _____ Unit# _____
City _____ State _____ ZIP _____
E-mail Address _____ Home Ph# (____) _____ Work Ph# (____) _____
Employer _____ Employer's Medical Insurance _____ Occupation _____

Total Annual Income of All Members of Applicant's Household* \$ _____ # of People in Household _____
**Defined as the sum of adjusted gross income from federal tax return for most recent year for all members of applicant's household. Documentation may be requested by HIPUtah to verify household income.*

Primary Care Physician Full Name _____ Street Address _____

Responsible Party (to be completed when applicant is a minor younger than age 18 or lacks the legal ability to contract)

Last Name _____ First Name _____ Middle Initial _____
Street Address _____ Unit# _____
City _____ State _____ ZIP _____
Social Security# _____ Date of Birth _____ / _____ / _____ Relationship to Applicant _____
Employer _____ Employer's Medical Insurance _____ Occupation _____

C. PRIOR HIPUTAH OR FEDERAL-HIPUTAH COVERAGE

Has applicant ever been covered by the HIPUtah or Federal-HIPUtah program before? Yes No
If yes, date coverage terminated _____ Reason for Termination _____
Was the lifetime policy maximum met? Yes No
Has the applicant had coverage similar to HIPUtah or Federal-HIPUtah in another uninsurable risk pool? Yes No
If yes: State _____ Plan _____ Dates of Coverage _____ / _____ / _____ to _____ / _____ / _____
Was the policy dollar maximum of the above coverage met? Yes No
Reason for Termination _____

SELECTHEALTH USE ONLY

Conditional Eligibility _____ State/Federal (circle one) _____
Effective Date _____ / _____ / _____ Points _____ HIPAA Eligible _____
Final Status Code _____ PEC _____

D. ELIGIBILITY REQUIREMENTS

- 1. Is the applicant lawfully admitted into or a citizen of the United States?
2. Is the applicant a resident of Utah?
3. Is the responsible party a resident of Utah?
4. Is the applicant currently covered by or eligible for Medicare?
5. Is the applicant currently covered by or eligible for Medicaid?
6. Is the applicant currently covered by or eligible for any other public health plan?
7. Is the applicant currently covered by or eligible for any health insurance?
8. If enrolled, would any employer reimburse or pay for any portion of this plan?
9. Has the applicant either voluntarily cancelled health insurance coverage or been involuntarily cancelled by a health insurance company within the last six months?

If you answered yes to any of the above, please complete section "E".

E. PRIOR/CURRENT COVERAGE INFORMATION

Will the applicant be losing coverage within the next six months for any reason?

If "Yes," give the dates of current coverage and the reason for termination below.

PRIOR/CURRENT HEALTH INSURANCE COVERAGE INFORMATION

Please complete the following information about your health insurance coverage for the last 18 months, regardless of whether it is still in effect.

Please include a letter of Creditable Coverage (termination letter) for those policies listed below with this application. The application process will be delayed if it is not included.

The following documentation is also acceptable for submission:

- Explanation of Benefits or other correspondence that indicates coverage
Health insurance ID card
Medical record that indicates health coverage
Pay stubs showing payroll deduction for health coverage
Certificate of coverage for a group health insurance policy
Other documentation that shows evidence of health coverage

LIST BELOW ALL CORRESPONDING INSURANCE POLICIES

Carrier Name
Coverage Effective Date
Termination Date
Reason for Coverage Termination
Type(s) of Coverage
Employer sponsored
COBRA
State extension
Individual
Group conversion
Government sponsored

Carrier Name
Coverage Effective Date
Termination Date
Reason for Coverage Termination
Type(s) of Coverage
Employer sponsored
COBRA
State extension
Individual
Group conversion
Government sponsored

Carrier Name
Coverage Effective Date
Termination Date
Reason for Coverage Termination
Type(s) of Coverage
Employer sponsored
COBRA
State extension
Individual
Group conversion
Government sponsored

F. UNINSURABILITY INFORMATION

1. Has the applicant been denied coverage from any other health insurance carrier? Yes No

If "Yes," please list the type(s) of coverage for which you have applied and the carrier(s): _____

Date of Application ____ / ____ / ____ Date of Denial _____ (Please attach a copy of denial letter)

2. Is an application to any other health insurance coverage currently in process for the applicant? Yes No

If "Yes," please list the type(s) of coverage for which you have applied and the carrier(s): _____

Date of Application ____ / ____ / ____

3. Does the applicant, spouse or parent, legal guardian or other responsible party work for an employer that offers health insurance benefits?

If "Yes," or "Unsure," list the name, address and phone number of each employer. Also list insurance carrier name and reason Applicant is not insured on this program:

Applicant Yes No Unsure _____

Spouse Yes No Unsure _____

Parent, Legal Guardian or other Responsible Party Yes No Unsure _____

4. Please list all current medical condition(s) that have prevented the applicant from obtaining other health insurance.

Note: All applicants must submit with this application copies of medical records or a physician letter documenting the above medical condition(s). Documentation must specifically show date of onset, diagnosis and prognosis of said medical condition(s). It is the applicant's responsibility to obtain these records at his or her expense. Even if disclosed, non-covered procedures/diagnosis and services provided or ordered to treat complications of a non-covered service, including gastric bypass are not covered.

G. AFFIRMATION

I, the applicant (or parent, legal guardian, or responsible party of applicant), affirm that my foregoing answers to questions in Section A through F are complete and correct to the best of my knowledge. I understand that no coverage will be in effect until the full initial premium is paid and this application has been approved and accepted by HIPUtah.

I understand that:

- "Preexisting condition," with respect to a health benefit plan means the following: (a) a condition that was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day; (b) does not include a condition indicated by genetic information unless an actual diagnosis of the condition by a physician has been made.
- Benefits otherwise payable under the policy will be reduced by all amounts paid or payable through any other health coverage, workers-compensation, motor vehicle coverage, or any state or federal law or program.
- If this application contains fraudulent or intentional misstatements or omissions, HIPUtah may do any or all of the following: (a) cancel the agreement as though it were never effective; (b) deny benefits under the "pre-existing condition" exclusion; or (c) take any other action available to it by law.
- I understand that if I am at least 18 years of age and I am not lawfully admitted to the United States, I am not eligible for HIPUtah.

Signature _____ Date ____ / ____ / ____

(Applicant's signature or signature of parent, legal guardian, or responsible party.)

Any matter in dispute between you and HIPUtah or Federal-HIPUtah may be subject to arbitration as an alternative to court action pursuant to the rules of the Utah Uniform Arbitration Act. Any decision reached by arbitration shall be binding upon both you and HIPUtah or Federal-HIPUtah. The arbitration award may include attorney's fees, if allowed by law, and may be entered as a judgment in any court of proper jurisdiction.

DISCLOSURE AUTHORIZATION

I authorize disclosure of medical record information about me (or about the applicant, if I am other than the Applicant) to HIPUtah or Federal-HIPUtah if needed to (a) determine eligibility for coverage; and/or (b) process claims for benefits.

This authorization takes effect on the date received by the Administrator and remains in effect as follows:

- For information needed to process a claim for benefits, the authorization is effective for the lifetime of the policy or the duration of the timely filing deadline for any claim, whichever is longer.
- For information needed to evaluate the application for coverage, the authorization will be effective for 90 days after the date received by the Administrator.

H. AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This authorization provides for the release of PHI to the Utah Comprehensive Health Insurance Pool (HIPUtah) through its Administrator. Federal privacy laws require health plans to include certain provisions in any authorization for use or disclosure of medical information, other than uses or disclosures for treatment, payment, healthcare operations, and as otherwise required or expressly permitted by law. If HIPUtah or SelectHealth needs to use, disclose, or receive PHI other than for the purposes set forth herein, I understand that I may be required to sign a separate authorization.

On behalf of myself (or the applicant if I am other than the applicant), I authorize any physician, healthcare provider, hospital, insurance, or reinsurance company, or other insurance information exchange to disclose PHI including alcohol, chemical dependency, mental treatment, genetic testing, or HIV treatment to HIPUtah, SelectHealth, or its representatives. I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan, eligibility for benefits, or payment of claims. PHI may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If I choose not to sign this authorization, SelectHealth on behalf of HIPUtah, may be unable to enroll me for coverage under HIPUtah or Federal-HIPUtah, or to pay claims that were incurred while I had insurance coverage with HIPUtah or Federal-HIPUtah.

I understand that I may cancel this authorization at any time by sending a written request to SelectHealth, Inc. at P.O. Box 30192, Salt Lake City, Utah 84130-0192. Cancellation of this authorization will not affect any action HIPUtah or SelectHealth took before it received my request. If I do not revoke this authorization, it will automatically expire upon termination of my coverage with HIPUtah or Federal-HIPUtah, or 24 months from the date at right, whichever comes first.

Federal law requires HIPUtah or SelectHealth to tell me that if the party to whom HIPUtah

or SelectHealth, Inc. discloses my PHI shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are subject to federal confidentiality rules (42 CFR part 2). Federal law prohibits redisclosure of such information without specific written authorization.

NAME _____ (Please Print)

SIGNATURE* _____ DATE _____

NAME _____ (Please Print)

SIGNATURE* _____ DATE _____

* If signed by a Personal Representative of the member/enrollee, please complete the following:

Personal Representative's Name _____

Relationship to Individual Parent Legal Guardian** Holder of Power of Attorney**

** Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(PSYCHOTHERAPY NOTES are notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation during a counseling session.)

I. PRODUCER INFORMATION

Producer Name (Last, First, Initial) _____ Social Security# _____

Insurance License# _____ Ph# (____) _____ E-mail Address _____

Street Address _____ City _____ State _____ ZIP _____



Payment Selection Form

Applicant's Name _____ Applicant's Social Security# OR Subscriber ID _____
(internal use only)

A. PAYMENT SELECTION

Please select one of the three 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.

- | | | |
|--|--|--|
| <input type="checkbox"/> Preauthorized Banking Withdrawal
Complete section "B" | <input type="checkbox"/> Online Billing and Payment
Complete section "C." You must include a check for the first month's premium
<small>You will receive a premium notice by mail once you are accepted</small> | <input type="checkbox"/> Monthly Statement
\$5 Monthly service fee required,
(Option not available on Federal-HIPUtah plan) |
|--|--|--|

B. PREAUTHORIZED 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 authorize SelectHealth to initiate debit entries to my (our) **Checking Account** **Savings Account**

Account Holder's Name _____ Account# _____

Financial Institution _____ Routing & Transit# _____

I understand that debit entries will be submitted to my account on or about the 10th of each month, regardless of the policy effective date. I understand that a **\$25.00 service charge** will be assessed if the premium amount cannot be deducted from my account for any reason.

Account Holder's Signature _____ Date _____

PREAUTHORIZED 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.

Check#	Routing & Transit#	Account#
00 1099	1 2400494 1	183940 1923

C. ONLINE BILLING AND PAYMENT

If you have selected the Online 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 a Web site where you can make your monthly payment by electronic check.

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

Applicant's Name _____ Applicant's Signature _____

Applicant's E-mail Address _____ Applicants Date of Birth _____

BEFORE YOU SUBMIT YOUR APPLICATION FORM, REMEMBER TO...

- Complete entire application**
- Complete Section B**
 - Including total annual income for all family members
- Complete Section D**
- Signatures of Applicant and Dates, Sections G and H**
- Include:**
 - Medical records or Physician letter showing diagnosis and prognosis of medical conditions.
 - Documentation of lawful admission to the U.S.
 - Health Savings Account Enrollment and Authorization Form, if you choose to establish an HSA with HealthEquity.

We appreciate your cooperation. Failure to complete this information may delay the review of your application and effective date of coverage.