



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 plan renewals or more. Families with dependents 18 or younger may only reapply at the time of their plan renewal.**

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 _____ Marital Status Single Legally Married Divorced Widowed

B. HEALTH INFORMATION

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

Subscriber	FIRST NAME	HEIGHT		WEIGHT (LBS)
		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, or do you anticipate adopting a child?
- 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

Do you have any family members who are not applying for coverage? If yes, complete "a" below. Yes No

a) List the name(s), age(s), relationship(s), and reason(s) why any family members are not applying for coverage, and describe their health status and where they are currently covered.

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. I acknowledge that this may cause my monthly premium to change. 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.

<input type="checkbox"/> Network	<input checked="" type="checkbox"/> select:value	<input type="checkbox"/> select:med	<input checked="" type="checkbox"/> select:care*	Select one network.
<input type="checkbox"/> Plan Option	<input type="checkbox"/> HMO	<input type="checkbox"/> NetCare	<input type="checkbox"/> HealthSave SM	Select one plan option and complete associated benefit section below.

HMO BENEFIT SECTION	HEALTHSAVE BENEFIT SECTION
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For HMO Plan option, complete this section.

BENEFIT AND DEDUCTIBLE

Select one deductible

- Base Plan – Deductible applies to most services except preventive care**
 - \$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)
- Base Plan With Office Deductible Waiver – No deductible for office visits**
 - \$500 Medical Deductible (\$250 Rx Ded)
 - \$1,000 Medical Deductible (\$500 Rx Ded)

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.**

NETCARE BENEFIT SECTION

For NetCare option, complete this section.

BENEFIT AND DEDUCTIBLE

Select one deductible

- \$1,500 Deductible
- \$3,500 Deductible

* Select Care network option not available for NetCare plans.

For HealthSave option, complete this section.

DEDUCTIBLE

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

- Single (One person)**
 - \$1,300 Deductible**** (20% coinsurance after deductible with a \$3,900 out-of-pocket maximum including deductible)
 - \$1,500 Deductible (20% coinsurance after deductible with a \$5,000 out-of-pocket maximum including deductible)
 - \$2,500 Deductible (20% coinsurance after deductible with a \$3,500 out-of-pocket maximum including deductible)
 - \$5,000 Deductible (Covered 100% after deductible)
- Family (Two or more)**
 - \$2,600 Deductible**** (20% coinsurance after deductible with a \$7,800 out-of-pocket maximum including deductible)
 - \$3,000 Deductible (20% coinsurance after deductible with a \$10,000 out-of-pocket maximum including deductible)
 - \$5,000 Deductible (20% coinsurance after deductible with a \$7,000 out-of-pocket maximum including deductible)
 - \$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

SelectHealth's preferred HSA vendor is HealthEquity®. An HSA will be established for you with HealthEquity if you choose this option (see box below). An administrative fee is included in your premium amount regardless of whether you choose to use the preferred HSA vendor. As with most HSA vendors, a nominal fee will also be charged if you choose to terminate the account once it has been established.

- 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** _____