



P.O. Box 30192 Salt Lake City, UT 84130-0192 801-442-5038/800-538-5038 selecthealth.org

TransitionSM Plan Application

A. APPLICANT INFORMATION (Must be oldest family member applying for coverage)

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____ Unit# _____ Marital Status Single Legally Married Separated Divorced

City _____ State _____ ZIP _____

Street Address (if different) _____

City _____ State _____ ZIP _____

Your Occupation _____ Your Spouse's Occupation _____

E-mail Address _____ Home Ph#(_____) _____ Work Ph#(_____) _____

Payment Option (See Payment Selection Form, pg. 4) Single Payment Monthly Payment

B. APPLICANT AND DEPENDENT INFORMATION

IN THE SECTION BELOW, LIST YOURSELF AND ELIGIBLE FAMILY MEMBERS TO BE INCLUDED UNDER MEDICAL COVERAGE.

RELATIONSHIP	NAME (FIRST, MIDDLE INITIAL, LAST)	SEX (M/F)	DATE OF BIRTH (MM/DD/YY)	AGE	SOCIAL SECURITY# (FOR INTERNAL USE ONLY)
Self					
Spouse					
Child					
Child					
Child					
Child					
Child					
Child					
Child					
Child					

- To be eligible for coverage, the applicant and all dependents must be younger than age 65. You cannot select a termination date later than the end of the month in which the applicant will turn 65.
- To be eligible for coverage, children must be younger than age 26. Dependents who are not listed will not be considered for coverage. You cannot select a termination date later than the end of the month in which a dependent turns 26.
- Infants are eligible after they have had their first routine checkup (usually two weeks).
- Once the application is accepted by SelectHealth, you will not be able to add or remove dependents during the plan term.

C. PRE-EXISTING CONDITION EXCLUSION NOTICE

Please note that all pre-existing conditions are excluded under the Transition plan. No pre-existing condition waiting period credit is given for previous coverage, regardless of whether or not there is a break in coverage. Pre-existing conditions are defined in the Transition plan Contract as follows:

A Pre-Existing Condition is any condition or symptom occurring within the two-year period preceding the effective date of coverage which would cause an ordinarily prudent person to seek diagnosis, care, or treatment; or a condition or symptom occurring in the two-year period preceding the effective date of coverage for which medical advice, care, or treatment was received from, or recommended by a physician; including but not limited to prescription and over-the-counter medication recommended by a provider.

SELECTHEALTH USE ONLY


Class# _____ Plan _____ Effective Date _____ Termination Date _____

Agent _____ Agent # _____

Rate Adjustment Percent _____ Monthly Payment \$ _____ PEC _____

Notes _____

D. PLAN INFORMATION

You can use any provider for covered services, but you are only protected from excess charges when you use providers who participate on the Select Care provider network. The logo that will appear on your ID Card looks like this: 

Select a Medical Deductible and Coinsurance/Maximum Coinsurance amount below.

MEDICAL DEDUCTIBLE

- \$250 Individual/\$750 Family
- \$500 Individual/\$1,500 Family
- \$1,000 Individual/\$2,500 Family
- \$2,500 Individual/\$5,000 Family

COINSURANCE AND MAXIMUM COINSURANCE

- 80%/20% - Maximum Coinsurance \$1,000 per person
- 50%/50% - Maximum Coinsurance \$2,500 per person

E. HEALTH INFORMATION

Instructions: Answer each question and consider each individual applying for medical coverage. If the answer to any of these questions is "yes," you will not be eligible for coverage on the Transition plan.

- Yes No Do you, or any dependent to be covered, have any other health insurance coverage?
- Yes No Are you, or any dependent to be covered, currently eligible for Medicare, or will you or any dependent become eligible for Medicare during the term of coverage you are selecting?
- Yes No Are you, or any dependent to be covered (if one or more apply, check "Yes"):
 - Currently pregnant or have reason to suspect you might be pregnant?
 - Financially responsible for an unborn child, anticipating adoption, applying for, or have applied for adoption?
 - Over 300 pounds if male or over 250 pounds if female?
- Yes No Have you, or any dependent to be covered, ever been declined for health insurance due to health reasons?
- 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?
- Yes No Within the past two years, have you, or any dependent to be covered, had a problem for which they have not sought medical advice or treatment?
- Yes No Within the past five years, have you, or any other dependent to be covered, received any abnormal test results, medical or surgical treatment, healthcare professional consultation, or prescribed medication for any of the following conditions?
 - AIDS or tested positive for HIV
 - Alcoholism, chemical dependency, drug or alcohol abuse
 - Cancer or tumor
 - Crohn's disease, ulcerative colitis, or hepatitis
 - Diabetes
 - Emphysema
 - Heart disorder, including any heart-related symptoms
 - Kidney disorder
 - Stroke

F. EFFECTIVE DATE

Coverage is not in force until your application is approved and an effective date is determined by SelectHealth®/SelectHealth Benefit Assurance Company (BAC). The minimum length of coverage is 30 days. The maximum length of coverage is six months (184 days). Coverage can start and end on any day of the month.

The start date must be within one month of the date the application is signed and will be the later of:

- the day after the completed application is received by SelectHealth, or
- the effective date listed on the application.

Requested Effective Date _____ **Requested End Date (Single payment option only)** _____

G. GENERAL INFORMATION

- 1. Are you self-employed?..... **Y N**
 - 1a. If you are not self-employed, is any employer reimbursing or paying for any portion of this plan? **Y N**
- 2. Does any listed eligible member live, reside, work, or attend school outside of Utah at any time during the year? **Y N**

Please explain "yes" answers to the above questions

H. PRIOR COVERAGE INFORMATION

Are you, or any dependent to be covered, currently covered under any SelectHealth plan, or have any applicants previously been covered under a SelectHealth Transition plan? Yes No

I. AUTHORIZATION AND ACKNOWLEDGMENT

The SelectHealth Transition plan is underwritten by SelectHealth BAC and administered by SelectHealth. I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with SelectHealth BAC. When incorporated with the Contract, this application and the Member Payment Summary (MPS) 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 SelectHealth/SelectHealth BAC, 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 SelectHealth/SelectHealth BAC, 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 question inaccurately, untruthfully, or incompletely, and I represent that such did not occur.

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 healthcare 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. 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 exclusion 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 furnished, you may intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by SelectHealth/SelectHealth BAC. Your new policy provides a ten-day examination period within which you may decide whether you desire to keep the plan. There is a processing fee of \$20 if you decide during the examination period that you will not keep the plan. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new plan.

1. Health conditions that you may presently have (pre-existing conditions) will not be covered under the new plan. This could result in a denial 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 current insurer or its agent regarding the proposed replacement of your current 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 current coverage.
3. If, after due consideration, you still wish to terminate your current 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 material 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.

Pre-Existing Conditions. I understand that any pre-existing condition or service rendered for a pre-existing condition, as defined on the first page of this application and in the Contract, is not covered by the Transition plan.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the health information on page two, 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 promptly provide that additional information to SelectHealth/SelectHealth BAC.

J. SIGNATURE OF APPLICANT AND SPOUSE

Signature _____ *Applicant Sign and Date Here* _____ Date Signed _____

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

K. 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 SelectHealth/SelectHealth BAC; or b) waive any of the terms or conditions of the Contract.
4. I have no authority to assign effective dates or to affect member changes.
5. Cancellation of this Healthcare Agreement by either the subscriber or SelectHealth BAC will terminate this Agency Agreement.

Date application received at SelectHealth.

Agent Name _____ Agency _____ Ph#() _____

Agent's Signature _____ *Agent/Broker Sign and Date Here* _____ Date Signed _____

Transition Plan Payment Selection Form

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

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.

Single Payment - Complete section B below.

You select both the start and end date of coverage and pay for the entire plan term in advance.

Monthly Payment - Complete section C below.

You select a start date and pay your first month's premium in advance. SelectHealth will automatically withdraw premium each month until: a) you notify SelectHealth in writing you wish to terminate your coverage, or b) you reach the maximum six months of coverage.

B. SINGLE PAYMENT OPTION

You may pay your full premium using a credit/debit card or with an electronic check.

Credit/Debit Card

Select Card Type

- Visa MasterCard®
 Discover® American Express®

Card# _____

Expiration Date _____

Name on Card _____

Billing ZIP _____

Electronic Check

Account Holder's Name _____

Account Holder's ZIP _____

Account# _____

Financial Institution _____

Routing and Transit# _____

Cardholder's Signature _____ Account Holder's Signature _____

C. MONTHLY PAYMENT OPTION

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 **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 tenth 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 _____

MONTHLY PAYMENT

Attach a Voided Check Here

Do not use a checking deposit slip.

Checking deposit slips do not always contain the necessary routing and transit information.

Check# Routing & Transit# Account#
00 1099 1 2400494 1 18 3940 19 23