



Utah Application Supplement Form Small Employer

For instructions regarding this application, please refer to section "G" on the next page.

Applicant's Name _____ Employer _____

A. MEDICAL PLAN INFORMATION

SELECT ONE FROM EACH OF THE FOLLOWING (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
- 2 - HealthSaveSM**—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)**
- 3 - NetCare**—If your employer has chosen NetCare, select one of the following plan options:
 Select Value Select MedSM

*Health Savings Account (HSA) (HealthSave Plans Only)—If your employer has chosen 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 *Health Savings Account Enrollment and Authorization to Disclose Health Information to HealthEquity form.*

B. DENTAL AND EYEWEAR COVERAGE

- If you would like SelectHealth DentalSM and/or SelectHealth EyewearSM coverage, complete section "C."
 If you do not want SelectHealth Dental coverage, complete section "D."

C. SELECTHEALTH DENTAL AND EYEWEAR BENEFIT SECTION

EMPLOYEE AND DEPENDENT INFORMATION (List yourself and eligible dependent(s) to be covered below.)

RELATIONSHIP	NAME (FIRST, MIDDLE INITIAL, LAST)	DENTAL (Y/N)	EYEWEAR (Y/N)	SEX	DATE OF BIRTH (MM/DD/YYYY)	AGE	SOCIAL SECURITY NUMBER	OTHER DENTAL INS.	NAME OF OTHER DENTAL INSURANCE 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	

D. WAIVER OF SELECTHEALTH DENTAL BENEFITS

Other Dental Carrier _____ Subscriber ID# _____ Policy Type Group Individual
 Policyholder's Name _____ Relationship to Policyholder _____

E. EMPLOYEE SIGNATURE

Employee Signature _____ Date Signed _____/_____/_____

F. AUTHORIZATION AND ACKNOWLEDGMENT

I hereby apply to be enrolled with my listed eligible dependent(s), if applicable, for coverage with SelectHealth. 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, 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 Group Health Insurance Contract with SelectHealth. I also understand no coverage will be in force until each person listed is approved by SelectHealth, that no benefits will be provided for any service which begins before coverage is effective, and that except as expressly provided in the Group Health Insurance Contract, benefits will not extend beyond the termination of either my coverage or the Group Health Insurance Contract. I represent that all information provided on this application 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 Group Health Insurance Contract may limit the healthcare providers whose services will be covered. I understand that the Group Health Insurance 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 Group Health Insurance Contract, healthcare services I obtain may not be covered. If the Group Health Insurance 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.

G. ENROLLMENT INSTRUCTIONS AND ADDITIONAL INFORMATION

You must read Section "F. 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, SelectHealth-appointed insurance agent, or a SelectHealth representative at **801-442-4908, option 2 or 800-442-3125, option 2.**

COMPLETE AND SIGN THE UTAH SMALL EMPLOYER HEALTH INSURANCE APPLICATION FORM

Applications 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.

EMPLOYEE AND DEPENDENT INFORMATION (Sections "B" and "C" on Utah Small Employer Health Insurance Application form)

Complete this section with all of the 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, unless they meet the criteria for disabled children as specified in the Certificate of Coverage. Any dependent not listed will not be considered for coverage.

CURRENT/PRIOR COVERAGE INFORMATION (Section "E" on Utah Small Employer Health Insurance Application form)

For coordination of benefit purposes, complete this section to indicate whether or not each member will be covered by other medical insurance while this health plan is in force.

NOTE: You must list other health insurance information for each member applying for coverage in order for SelectHealth to coordinate benefits with other carriers when necessary.

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 proof of prior coverage, such as a Certificate of Creditable Coverage, for each member. You have the right to request a Certificate of Creditable Coverage from your prior carrier. If necessary, SelectHealth will assist in obtaining such Certificates.

COMPLETE AND SIGN THE SMALL EMPLOYER SUPPLEMENT FORM

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