

New Group Data Summary Small Employer

Use this form for new group submissions only.

Company Name _____
Street Address _____
City _____ State _____ ZIP _____ Ph# (_____) _____
Company Key Contact _____ Company Fax# (_____) _____
Billing Address (If different than above, e.g., P.O. Box) _____ Billing Contact _____
City _____ State _____ ZIP _____ Billing Ph# (_____) _____
Proposed Effective Date _____ Writing Agent Name _____ Ph# (_____) _____
General Agency (GA) Affiliation, if applicable _____
Name of current group carrier, if applicable _____ Coverage dates: From _____ To _____
Reason for changing carriers Rate increase Poor service Benefits Other _____
Federal tax ID# _____ Number of years in business _____
Employer contribution amount — \$ amount OR % amount (minimum 50%) Employee _____
Total number of full-time employees now _____ Total number of full-time employees one year ago _____
Are any employees eligible for or on COBRA or Utah mini-COBRA? Yes No (If yes, each employee must submit a completed Employee Application)
Have all employees completed and signed their own application? Yes No Employer Initials _____ Agent Initials _____
Payment method Preauthorized Banking Withdrawal Web Pay Monthly Payment (add \$25 monthly administration fee)

A. TRADITIONAL MEDICAL PLAN (If you are selecting any other medical plan, leave this section blank)

SELECT FROM THESE OPTIONS FOR TRADITIONAL PLANS:

Medical Deductible Option \$250 \$500 \$1,000 \$2,000
Coinsurance and Copay (PCP/SCP) 80%/20% 80%/20%
\$25/\$40 \$35/\$50
Deductible for Office Visits/Prescription Drugs Waiver of Deductible for Office Visits — Select **one** of the two prescription drug options below:
 Rx Deductible Waiver Rx Deductible* (per person/calendar year)
 No Waiver of Deductible for Office Visits or Rx
Maternity Option Covered as any other illness Separate \$7,500 maternity deductible, per pregnancy (required for groups with 15+ employees)
Mental Health Option Standard (50%/50%) Parity (required for groups with 51+ employees)
Supplemental Accident Option Yes No
If your Medical Deductible is: \$250 \$500 \$1,000 \$2,000
Your Rx Deductible* is: \$150 \$250 \$500 \$1,000

*Tier 1 drugs (primarily generic drugs) are covered before the Rx deductible on all plans.

B. NETCARE MEDICAL PLAN (If you are selecting any other medical plan, leave this section blank)

SELECT FROM THESE OPTIONS FOR NETCARE:

| Deductible Option (Single/Family) | Coordinating Out-of-Pocket Maximum |
|---|------------------------------------|
| <input type="checkbox"/> 1 \$1,500/\$4,500 | \$5,000/\$15,000 |
| <input type="checkbox"/> 2 \$3,500/\$10,500 | \$10,000/\$30,000 |

Mental Health Option Standard (70%/30%) Parity (required for groups with 51+ employees)

C. HEALTHSAVESM MEDICAL PLAN (If you are selecting any other medical plan, leave this section blank)

SELECT FROM THESE OPTIONS FOR HEALTHSAVE:

Deductible Option (Single/Family)

- 1** \$1,300/\$2,600
- 2** \$1,500/\$3,000
- 3** \$2,500/\$5,000
- 4** \$5,000/\$10,000

Coordinating Out-of-Pocket Maximum

- \$3,900/\$7,800
- \$5,000/\$10,000
- \$3,500/\$7,000
- \$5,000/\$10,000

Maternity Option

- Covered as any other illness (required for groups with 15+ employees) Not covered

Mental Health Option

- Standard (50%/50%) Parity (required for groups with 51+ employees)

Health Savings Account

- Yes** No

***By choosing yes, you have opted to use HealthEquity®, SelectHealth's preferred vendor for HSA administration. Account fee is \$2.95 per account holder per month and will be included on your monthly bill.*

D. SELECTHEALTH DENTALSM (Available with all plans)

Dental Deductible

- \$0 \$50 \$100

Annual Maximum Benefit

- \$1,000 \$1,500 \$2,000

Orthodontics (for contributory plans with at least ten enrolling employees only)

- Yes No

If yes, choose lifetime maximum

- \$1,000 \$1,500

Nonparticipating Coinsurance (Traditional is 80% preventive/60% basic/40% major)

- Upgrade to 100% preventive/80% basic/50% major

Prior Coverage

- Yes, with orthodontics Yes, without orthodontics No

Employer Contribution

- Contributory (50% or more is required) Voluntary

E. SELECTHEALTH EYEWEAR (Must select Medical coverage to enroll. Available with all plans)

SELECT FROM THESE OPTIONS FOR EYEWEAR:

Lenses

- A** \$10
- B** \$20
- C** \$25

Frames

- \$100
- \$150
- \$200

Contacts

- \$115
- \$150
- \$200

Allowance (per year)

- D** \$200
- E** \$300

Employer Contribution

- Contributory (50% or more is required) Voluntary

F. SIGNATURE

Employer Signature _____ Date _____

Broker Signature _____ Date _____