

## Group Application Medical

(For new and renewing groups)

Employer applies to SelectHealth for group health coverage as outlined below.

Unless otherwise noted on page 4, selections and requirements that apply to medical also apply to eyewear.

### A. COMPANY INFORMATION

Company Name \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Company Ph# (\_\_\_\_\_) \_\_\_\_\_

Business Type  Corporation  Sole Proprietorship  Partnership  Nonprofit  LLC

Nature of Business \_\_\_\_\_

### B. PLAN SERVICE AREA

The service area for each plan is listed below:

#### Select Value<sup>SM</sup>

The Select Value service area includes the following counties: Davis, Salt Lake, Weber and parts of Utah County. However, not all ZIP codes within these counties are included. As of January 2011, the following ZIP codes are NOT part of the Select Value service area: 84013, 84626, 84633, 84651, 84653, 84655, and 84660.

#### Select Med<sup>SM</sup>/Select Med Plus<sup>SM</sup>

The Select Med Plus service area includes the following counties: Beaver, Cache, Davis, Duchesne, Iron, Juab, Millard, Morgan, Salt Lake, Sanpete, Sevier, Summit, Utah, Wasatch, Washington, Weber, and parts of Box Elder Garfield, Piute, Tooele, Uintah, and Wayne. However, not all ZIP codes within these counties are included. As of January 2011, the following ZIP codes are NOT part of the Select Med Plus service area: 84008, 84034, 84035, 84078, 84079, 84083, 84313, 84329, 84712, 84716, 84717, 84718, 84723, 84734, 84736, 84759, 84764, and 84776.

#### Select Care<sup>SM</sup>/Select Care Plus<sup>SM</sup>

The Select Care Plus service area includes the following counties: Beaver, Cache, Davis, Duchesne, Garfield, Iron, Juab, Kane, Millard, Morgan, Piute, Rich, Salt Lake, Sanpete, Sevier, Summit, Uintah, Utah, Wasatch, Washington, Wayne, Weber, and parts of Box Elder and Tooele. However, not all ZIP codes within these counties are included. As of January 2011, the following ZIP codes are NOT part of the Select Care Plus service area: 84034, 84083, 84313, and 84329.

### C. EMPLOYEE RECONCILIATION

\_\_\_\_\_ Number of full-time employees\*

\_\_\_\_\_ Number of employees enrolling

\_\_\_\_\_ Number of ineligible employees (part-time, etc.)

\_\_\_\_\_ Number of employees waiving due to other group coverage

\_\_\_\_\_ Number of employees waiving without other coverage

\_\_\_\_\_ Number of employees currently in a new hire waiting period

\* Owners, officers, partners, and all other employees who work no less than thirty hours per week on a regular basis wherein an employer/employee relationship exists and where taxes are deducted from a salary. Independent contractors, leased, part-time, temporary, and retired employees are not eligible.

## D. MONTHLY PREMIUM

On or before the first day of each month, the employer shall pay SelectHealth the premium per the rate schedule.

## E. ELIGIBILITY, CONTRIBUTION, AND ENROLLMENT CRITERIA

Mandatory employee eligibility and enrollment requirements that the employer must satisfy as a condition to the initial and continued effectiveness of this contractual arrangement are as follows:

### 1. \*New Hire Eligibility Period:

Effective date will be the first of the month following

1 month       2 months       3 months (Following the date of hire)

Options below are available ONLY for groups of five or more enrolling employees.

6 months     9 months     12 months

Dual waiting periods for separate classes (classes determined by employer) \_\_\_\_\_ / \_\_\_\_\_

- Combination of any two of the six waiting periods listed above (one month to 12 months)

\*The New Hire Eligibility Period can only be changed twice: once at renewal and once outside of the renewal period.

### 2. Employer Monthly Contribution

Employer must contribute an amount equivalent to at least 50 percent of the lowest single coverage monthly Premium. The employer contribution must be consistent for all employee classes.

### 3. Minimum Number of Employees

A minimum of two employees must be approved for group eligibility at all times. For the determination of a group of two, the spouse of the employee will not be considered as an eligible employee. *Dual Option Only:* A minimum of ten employees must be approved for group eligibility at all times.

#### Required minimum Employee enrollment

- Employers with up to 14 enrolling employees - 100 percent must participate
- Employers with 15 or more enrolling employees - 75 percent must participate

*Employees waiving coverage due to other group coverage will not be counted toward participation.*

### 4. Dependent Age Limitations

Dependent children are eligible for coverage up to age 26.

### 5. Termination of Coverage

Employee and dependent(s) coverage will terminate as of the end of the month in which termination of eligibility occurs. However, when an event causing loss of eligibility should have resulted in a member's retroactive termination, but the retroactive termination is not allowed under federal or state law, SelectHealth has the discretion to determine the prospective date of termination. SelectHealth also has the discretion to determine the date of termination for rescissions (as defined in the Group Health Insurance Contract).

### 6. Leave of Absence

Eligible employees are granted a leave of absence by the employer for up to sixty days.

### 7. Employee Status

A person may only be considered an employee if the employer withholds and pays to the government Social Security and Medicare taxes and income tax withholding on the employee's wages.

## F. DURATION OF GROUP HEALTH INSURANCE CONTRACT

If SelectHealth's minimum employee participation and employer contribution requirements are satisfied, the Group Health Insurance Contract and its terms shall commence on the effective date for a term of twelve months.

## G. MEMBER PAYMENT SUMMARY

In addition to any other applicable premium, members shall pay the copay/coinsurance amount per occurrence on the attached Member Payment Summary. "Not Covered" on the Member Payment Summary indicates that the service is not covered regardless of any other statement of coverage in Exhibit A or otherwise.

## H. PRE-EXISTING CONDITIONS

If applicable, Pre-Existing Conditions (PEC) will not be covered for newly covered plan members as described in the attached Group Health Insurance Contract, Member Payment Summary, and Employer Plan Coverage List.

## I. SIGNATURE

When a separate Employer Plan Coverage List is countersigned by SelectHealth and attached to this document, then this document, the Employer Plan Coverage List, and the Group Health Insurance Contract (including the Member Payment Summary) become the agreement between SelectHealth and employer. In case of discrepancies, the Employer Plan Coverage List and the Group Health Insurance Contract will prevail over this document.

Coverage, if approved, is made on the basis of information provided to SelectHealth by the employer and its employees and is subject to the above criteria as well as properly completed member applications. Employer understands that SelectHealth is relying on such information in making decisions about coverage and payment. Member applications must be submitted to and approved by SelectHealth's Underwriting department before the proposed effective date. Otherwise, SelectHealth may delay the effective date of issue of this Contract.

This Group Application must be signed by employer and received by SelectHealth before the Group Health Insurance Contract can be finalized.

Company Name \_\_\_\_\_

Owner, sign here \_\_\_\_\_

Owner, print name here \_\_\_\_\_

Date \_\_\_\_\_

***Continue to the next page if you wish to apply for eyewear coverage.***

# Eyewear Group Application

**Employer applies to SelectHealth for group eyewear coverage as outlined below.  
Unless otherwise noted below, selections and requirements that apply to medical also apply to eyewear.**

SelectHealth partners with EyeMed Vision Care® as the eyewear vendor for customer service and claims, and for provider access.

## J. PLAN SERVICE AREA

The service area for SelectHealth Eyewear<sup>SM</sup> includes the entire United States.

## K. ELIGIBILITY, CONTRIBUTION, AND ENROLLMENT CRITERIA

### 1. New Hire Eligibility Period

Must be equal to the new hire eligibility period for medical.

### 2. Employer Monthly Contribution (select one of the following):

- Contributory** (Employer must contribute an amount equivalent to at least 75 percent of the single coverage monthly Premium. The employer contribution must be consistent for all employee classes.)
- Voluntary** (Employer is not required to contribute to the employees' monthly premium.)

### 3. Required Minimum Employee Enrollment

A minimum of five employees must be enrolled at all times. There is no minimum enrollment percentage for participation.

\_\_\_\_\_ Number of employees enrolling for eyewear coverage

## L. OTHER REQUIREMENTS

SelectHealth Eyewear may not be purchased as a standalone product without also purchasing medical coverage. However, employees may elect eyewear coverage for themselves and dependents without also enrolling for medical.

## M. SIGNATURE

When a separate Employer Plan Coverage List is countersigned by SelectHealth and attached to this document, then this document, the Employer Plan Coverage List, and the Group Eyewear Contract become the agreement between SelectHealth and employer. In case of discrepancies, the Employer Plan Coverage List and the Group Eyewear Contract will prevail over this document.

Coverage, if approved, is made on the basis of information provided to SelectHealth by the employer and its employees and is subject to the above criteria as well as properly completed member applications. Employer understands that SelectHealth is relying on such information in making decisions about coverage and payment. Member applications must be submitted to and approved by SelectHealth's Underwriting department before the proposed effective date. Otherwise, SelectHealth may delay the effective date of issue of this Contract.

This Group Application must be signed by employer and received by SelectHealth before the Group Eyewear Contract can be finalized.

Company Name \_\_\_\_\_

Owner, sign here \_\_\_\_\_

Owner, print name here \_\_\_\_\_

Date \_\_\_\_\_