



# HIPUtah New Enrollee Application Form

Please use dark ink and print legibly. Do not write in shaded areas

Administered by SelectHealth

## A. COVERAGE AND PAYMENT INFORMATION

### Coverage

Select one deductible/out-of-pocket

- \$500 Deductible/\$2,000 Out-of-Pocket Maximum
- \$1,000 Deductible/\$3,000 Out-of-Pocket Maximum
- \$2,500 Deductible/\$6,000 Out-of-Pocket Maximum
- \$5,000 Deductible (HDHP)/\$5,000 Out-of-Pocket Maximum

### Payment Option

- Direct Monthly Billing (\$5.00 monthly service fee applies)
- Preauthorized Banking Withdrawal
- Online Billing and Payment (See Payment Selection Form)

Desired Effective Date \_\_\_\_\_

## B. APPLICANT INFORMATION

Note: Every person applying for a HIPUtah policy must complete a separate application, including members of the same family.

### Applicant

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Social Security# \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex  M  F

Street Address \_\_\_\_\_ Unit# \_\_\_\_\_

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

E-mail Address \_\_\_\_\_ Home Ph# (\_\_\_\_) \_\_\_\_\_ Work Ph# (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Medical Insurance \_\_\_\_\_ Occupation \_\_\_\_\_

# of People in Household \_\_\_\_\_

Total Annual Income of All Members of Applicant's Household\* \$ \_\_\_\_\_

\*Defined as the sum of adjusted gross income from federal tax return for most recent year for all members of applicant's household. Documentation may be requested by HIPUtah to verify household income and **is required on application.**

Primary Care Physician Full Name \_\_\_\_\_ Street Address \_\_\_\_\_

### Responsible Party (to be completed when applicant is a minor under age 16 or lacks the legal ability to contract)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Street Address \_\_\_\_\_ Unit# \_\_\_\_\_

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

Social Security# \_\_\_\_-\_\_\_\_-\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Medical Insurance \_\_\_\_\_ Occupation \_\_\_\_\_

## C. PRIOR HIPUTAH COVERAGE

Has applicant ever been covered by the HIPUtah program before?  Yes  No

If yes, date coverage terminated \_\_\_\_\_ Reason for Termination \_\_\_\_\_

Was the lifetime policy maximum met?  Yes  No

Has the applicant had coverage similar to HIPUtah in another state's uninsurable risk pool?  Yes  No

If yes: State \_\_\_\_\_ Plan Ph# (\_\_\_\_) \_\_\_\_\_ Dates of Coverage \_\_\_\_\_ to \_\_\_\_\_

Was the policy dollar maximum of the above coverage met?  Yes  No

Reason for Termination \_\_\_\_\_

## SELECTHEALTH USE ONLY

Conditional Eligibility \_\_\_\_\_ Premium \$ \_\_\_\_\_ Class# \_\_\_\_\_

Effective Date \_\_\_\_\_ Points \_\_\_\_\_ HIPAA Eligible \_\_\_\_\_

Final Status Code \_\_\_\_\_ PEC \_\_\_\_\_

## D. ELIGIBILITY REQUIREMENTS

**1. Is the applicant a resident of Utah?**  Yes  No

If "Yes," how long has he or she been a continuous Utah resident? \_\_\_\_\_ years \_\_\_\_\_ months

**2. Is the applicant lawfully admitted into or a citizen of the United States?**  Yes  No

If "Yes," and at least 18 years of age, please provide documentation such as U.S. Passport, U.S. Birth Certificate, Certificate of Citizenship, I-94 Card, Resident Alien Card, or Certificate of Naturalization, etc.

**3. Is the responsible party a resident of Utah?**  Yes  No

If "Yes," how long has he or she been a continuous Utah resident? \_\_\_\_\_ years \_\_\_\_\_ months

**4. Is the applicant currently covered by or eligible for Medicare?**  Yes  No

If "Yes," Medicare number \_\_\_\_\_ Effective date \_\_\_\_\_

**5. Is the applicant currently covered by or eligible for Medicaid?**  Yes  No

If "Yes," Medicaid number \_\_\_\_\_ Effective date \_\_\_\_\_

**6. Is the applicant currently covered by or eligible for any other public health plan?**  Yes  No

If "Yes," program name \_\_\_\_\_ Effective date \_\_\_\_\_

**7. Is the applicant currently covered by or eligible for any health insurance? (Including employer-sponsored, state extension, COBRA, or group conversion)**  Yes  No

If "Yes," health insurance carrier name \_\_\_\_\_ Effective date \_\_\_\_\_

**8. If enrolled, would any employer reimburse or pay for any portion of this plan?**  Yes  No

**9. Has the applicant either voluntarily cancelled health insurance coverage or been involuntarily cancelled by a health insurance company within the last six months?**  Yes  No

If "Yes," please answer the following questions:

- |  |  |
|--|--|
| a. Was the coverage under an employer-sponsored program?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Was the coverage under COBRA or state extension?                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Was the COBRA or state extension coverage exhausted?                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Was the coverage under an individual plan?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Was the coverage under a group conversion plan?                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Was the coverage under a government-sponsored plan (e.g. Medicare, Medicaid, etc.)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Did your employer drop insurance coverage?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Were you self-employed?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Did you lose employment?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Other reasons for loss of coverage _____  |  |

If you answered yes to any of the above, please complete section "E".

## E. PRIOR/CURRENT COVERAGE INFORMATION

**Will the applicant be losing coverage within the next six months for any reason?**  Yes  No

If "Yes," give the dates of current coverage and the reason for termination below.

### PRIOR/CURRENT HEALTH INSURANCE COVERAGE INFORMATION

Please complete the following information about your health insurance coverage for the last 18 months, regardless of whether it is still in effect. If you have had coverage through more than one insurance carrier in that time, please include coverage information for each carrier.

Failure to complete information on this form could result in no credit toward the pre-existing condition waiting period.

**Please include a letter of Creditable Coverage (termination letter) for those policies listed below with this application.  
The application process will be delayed if it is not included.**

**The following documentation is also acceptable for submission:**

- |   |   |
|---|---|
| • Explanation of Benefits or other correspondence that indicates coverage | • Pay stubs showing payroll deduction for health coverage     |
| • Health insurance ID card  | • Certificate of coverage for a group health insurance policy |
| • Medical record that indicates health coverage                           | • Other documentation that shows evidence of health coverage  |

**LIST BELOW ALL CORRESPONDING INSURANCE POLICIES**

	CARRIER 1	CARRIER 2	CARRIER 3
<b>1. TYPE(S) OF COVERAGE</b>			
Employer sponsored			
COBRA			
State extension			
Individual			
Group conversion			
Government sponsored			
<b>2. COVERAGE EFFECTIVE DATE</b>			
<b>3. TERMINATION DATE</b>			
<b>4. INSURANCE CARRIER PH#</b>			
<b>5. REASON FOR COVERAGE TERMINATION</b> (e.g., loss of job, coverage dependent, COBRA expiration, employer dropped coverage, nonpayment of premiums)			

**F. UNINSURABILITY INFORMATION**

1. Has the applicant been denied coverage from any other health insurance carrier?  Yes  No

If "Yes," please list the type(s) of coverage for which you have applied and the carrier(s): \_\_\_\_\_

Date of Application \_\_\_\_\_ Date of Denial \_\_\_\_\_

2. Is an application to any other health insurance coverage currently in process for the applicant?  Yes  No

If "Yes," please list the type(s) of coverage for which you have applied and the carrier(s): \_\_\_\_\_

Date of Application \_\_\_\_\_

3. Does applicant, spouse or parent, legal guardian or other responsible party work for an employer that offers health insurance benefits?

If "Yes," or "Unsure," list the name, address and phone number of each employer. Also list insurance carrier name and reason Applicant is not insured on this program:

Applicant  Yes  No  Unsure \_\_\_\_\_

Spouse  Yes  No  Unsure \_\_\_\_\_

Parent, Legal Guardian or other Responsible Party  Yes  No  Unsure \_\_\_\_\_

4. Please list all current medical condition(s) that have prevented the applicant from obtaining other health insurance.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note: All applicants must submit with this application copies of medical records or a physician letter documenting the above medical condition(s). Documentation must specifically show date of onset, diagnosis and prognosis of said medical condition(s). It is the applicant's responsibility to obtain these records at his or her expense.**

**G. AFFIRMATION**

I, the applicant (or parent, legal guardian or responsible party of applicant), affirm that my foregoing answers to questions in Section A through F are complete and correct to the best of my knowledge. I understand that no coverage will be in effect until the full initial premium is paid and this application has been approved and accepted by HIPUtah.

I understand that:

- "Preexisting condition," with respect to a health benefit plan means the following: (a) a condition that was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day; (b) does not include a condition indicated by genetic information unless an actual diagnosis of the condition by a physician has been made.
- Benefits otherwise payable under the policy will be reduced by all amounts paid or payable through any other health coverage, workers compensation, motor vehicle coverage, or any state or federal law or program.
- If this application contains fraudulent or material misstatements or omissions, HIPUtah may do any or all of the following: (a) cancel the agreement as though it were never effective; (b) deny benefits under the "pre-existing condition" exclusion; or (c) take any other action available to it by law.
- I understand that if I am at least 18 years of age and I am not lawfully admitted to the United States, I am not eligible for HIPUtah.

Any matter in dispute between you and HIPUtah may be subject to arbitration as an alternative to court action pursuant to the rules of the Utah Arbitration Act. Any decision reached by arbitration shall be binding upon both you and HIPUtah. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

**DISCLOSURE AUTHORIZATION**

I authorize disclosure of medical record information about me (or about the applicant, if I am other than the Applicant) to HIPUtah if needed to (a) determine eligibility for coverage; and/or (b) process claims for benefits.

This authorization takes effect on the date received by the HIPUtah administrator and remains in effect as follows:

- For information needed to process a claim for benefits, the authorization is effective for the lifetime of the HIPUtah policy or the duration of the timely filing deadline for any claim, whichever is longer.
- For information needed to evaluate the application for coverage, the authorization will be effective for 90 days after the date received by the HIPUtah Administrator.

I understand and agree that by typing in my name I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

**Signature**

Please type your signature in the box below.

\_\_\_\_\_

Please verify your signature by typing it again.

\_\_\_\_\_

Date Signed.

\_\_\_\_\_

## H. AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This authorization provides for the release of PHI to the Utah Comprehensive Health Insurance Pool (HIPUtah) through its administrator SelectHealth. Federal privacy laws require health plans to include certain provisions in any authorization for use or disclosure of medical information, other than uses or disclosures for treatment, payment, healthcare operations, and as otherwise required or expressly permitted by law. If HIPUtah or SelectHealth needs to use, disclose, or receive PHI other than for the purposes set forth herein, I understand that I may be required to sign a separate authorization.

On behalf of myself (or the applicant if I am other than the applicant), I authorize any physician, healthcare provider, hospital, insurance, or reinsurance company, or other insurance information exchange to disclose PHI including alcohol, chemical dependency, mental treatment, genetic testing, or HIV treatment to HIPUtah, SelectHealth, or its representatives. I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan, eligibility for benefits, or payment of claims. PHI may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If I choose not to sign this authorization, SelectHealth on behalf of HIPUtah, may be unable to enroll me in the HIPUtah health plan or to pay claims that were incurred while I had insurance coverage with HIPUtah.

I understand that I may cancel this authorization at any time by sending a written request to SelectHealth, Inc. at P.O. Box 30192, Salt Lake City, Utah 84130-0192. Cancellation of this authorization will not affect any action HIPUtah or SelectHealth took before it received my request. If I do not revoke this authorization, it will automatically expire upon termination of my coverage with HIPUtah or 24 months from the date at right, whichever comes first.

Federal law requires HIPUtah or SelectHealth to tell me that if the party to whom HIPUtah or SelectHealth, Inc. discloses my PHI shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are subject to federal confidentiality rules (42 CFR part 2). Federal law prohibits redisclosure of such information without specific written authorization.

I understand and agree that by typing in my name I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

### Signature

Please type your signature in the box below.

Please verify your signature by typing it again.

Date Signed.

I understand and agree that by typing in my name I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

### Signature\*

Please type your signature in the box below.

Please verify your signature by typing it again.

Date Signed.

\* If signed by a Personal Representative of the member/enrollee, please complete the following:

Personal Representative's Name \_\_\_\_\_

Relationship to Individual Parent Legal Guardian\*\* Holder of Power of Attorney\*\*

\*\* Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

### THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(PSYCHOTHERAPY NOTES are notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation during a counseling session.)

## I. PRODUCER INFORMATION

Producer Name (Last, First, Initial) \_\_\_\_\_ Social Security# \_\_\_\_\_

Insurance License# \_\_\_\_\_ Ph# (\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_



## HIPUtah Payment Selection Form

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

### A. PAYMENT SELECTION

Please select one of the three 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.

- Preauthorized Banking Withdrawal**       **Online Billing and Payment**       **Monthly Statement**
- Complete section "B"      Complete section "C". You must include a check for the first month's premium      \$5 Monthly service fee required
- You will receive a premium notice by mail once you are accepted

### B. PREAUTHORIZED BANKING WITHDRAWAL

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 (our)  **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 10<sup>th</sup> 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. I understand and agree that by typing in my name I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

#### Account Holder's Signature

Please type your signature in the box below.

Please verify your signature by typing it again.

Date Signed.

### PREAUTHORIZED BANKING WITHDRAWAL

#### Attach a Voided Check Here

Do not use a checking deposit slip for checking withdrawal.  
Checking deposit slips do not always contain the necessary routing and transit information.

Check#      Routing & Transit#      Account#

00 1099      1 2400494 1      1839401923

### C. ONLINE BILLING AND PAYMENT

If you have selected the Online Billing and Payment option, complete and sign the agreement below. You will receive your monthly statement by E-mail. This E-mail will link you to a Web site where you can make your monthly payment by electronic check.

Premium payments are due on the first day of each month.

Applicant's Name \_\_\_\_\_ Applicants Date of Birth \_\_\_\_\_

Applicant's E-mail Address \_\_\_\_\_

I understand and agree that by typing in my name I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

#### Applicant's Signature

Please type your signature in the box below.

Please verify your signature by typing it again.

Date Signed.