SelectHealth complies with Federal civil rights laws. We do not discriminate or treat you differently because of your race, color, national origin, age, disability, or sex.

We provide free:

> Aid to those with disabilities to help them communicate with us, such as sign language interpreters and written information in other formats (large print, audio, electronic formats, other).

> Language help for those whose first language is not English, such as Interpreters and member materials written in other languages.

For help, call SelectHealth Member Services at 1-800-538-5038 (TTY Users: 711)

If you feel you've been treated unfairly, call SelectHealth 504/Civil Rights Coordinator at 1-844-208-9012 (TTY Users: 711) or the Compliance Hotline at 1-800-442-4845 (TTY Users: 711). You may also call the Office for Civil Rights at 1-800-368-1019 (TTY Users: 1-800-537-7697).

Language Access Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Lláme a SelectHealth: 1-800-538-5038.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 SelectHealth: 1-800-538-5038。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth: 1-800-538-5038.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth: 1-800-538-5038.

번으로 전화해 주십시오.


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Individual Plans  Utah Supplemental Application Form

Applicant’s Name __________________________ Applicant’s Social Security # OR Date of Birth __________________________

A. MEDICAL PLAN INFORMATION

Select a network, then select one of the following plans, including any associated benefit options.

Network Options  ❑ SelectHealth Value  ❑ SelectHealth Med

For more information, visit selecthealth.org/individualplans.

B. SELECTHEALTH DENTAL PLAN INFORMATION

SELECTHEALTH HEALTHSAVE

HSA QUALIFIED*

The deductible applies to all covered care except preventive care.

❑ HealthSave Expanded Bronze 6850 (HSA Qualified) – Rewards – $6,850 Medical and Rx Deductible Combined
❑ HealthSave Expanded Bronze 4000 (HSA Qualified) – $4,000 Medical and Rx Deductible Combined
❑ HealthSave Silver 3250 (HSA Qualified) – $3,250 Medical and Rx Deductible Combined

SelectHealth designed the HealthSave plans to be in compliance with the requirements for a High-Deductible Health Plan (HDHP) under federal law (Section 223 of the Internal Revenue Code). However, SelectHealth makes no representations or warranties about the legal adequacy of this coverage as an HSA-eligible plan. SelectHealth is not responsible for any issues relating to your use of the coverage in conjunction with an HSA including, without limitation, your compliance with the requirements of the Internal Revenue Code.

*HSA-qualified plans have a minimum deductible requirement. Some Cost-Share Reduction (CSR) plans do not meet that requirement.

HSA VENDOR

The SelectHealth preferred HSA vendor is HealthEquity. An HSA will be established for you with HealthEquity if you choose an HDHP unless you opt out (see option below). An administrative fee is included in your premium whether or not you choose to use the preferred HSA vendor. As with most HSA vendors, a nominal fee will be charged if you choose to terminate the account once it has been established.

❑ HealthEquity HSA Opt Out
   ❑ I do not plan to open an HSA or I plan to use another administrator.

CATASTROPHIC PLAN

Catastrophic plans are available for those who are under age 30 or those who qualify for a hardship exemption.

❑ Catastrophic 8150 – $8,150 Medical and Rx Deductible Combined

A dental policy provides dental benefits only. Review your policy carefully.
Individual Plans Payment Selection Form

Applicant’s Name ________________________________ Applicant’s Social Security# OR Date of Birth ____________________________ (internal use only)

A. PAYMENT SELECTION

Please select a method of payment for your monthly premium. SelectHealth® will accept third-party premium payments only when required by state or federal law. Please submit only personal account information.

- [ ] Preauthorized Banking Withdrawal
- [ ] Online Billing and Payment

(Complete Section “B.”) (Complete Section “C.”)

B. PREAUTHORIZED BANKING WITHDRAWAL

If you select this method of payment for your monthly premium, your payment will be deducted automatically from your checking/savings account each month. Please complete the information below.

I authorize SelectHealth to initiate withdrawals from my [ ] Checking Account [ ] Savings Account

Account Holder’s Name _____________________________________________ Account# _____________________________________________

Financial Institution _____________________________________________ Routing & Transit# _____________________________________________

I understand that debit withdrawals will be submitted to my account on or about the 10th of each month, regardless of the policy effective date. I understand that a $25.00 service charge may be applied if the premium amount cannot be deducted from my account for any reason.

Account Holder’s Signature _____________________________________________ Date __________________________

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.

<table>
<thead>
<tr>
<th>Check#</th>
<th>Routing &amp; Transit#</th>
<th>Account#</th>
</tr>
</thead>
<tbody>
<tr>
<td>00 1099</td>
<td>124004941</td>
<td>1839401923</td>
</tr>
</tbody>
</table>

C. ONLINE BILLING AND PAYMENT

Once you receive notification that your application has been approved, please call us at 800-442-0220 to make your first month’s payment. After your first payment, all future monthly statements will be sent via email. The statement emails will direct you to a website where you can pay online with a debit or credit card. Premium payments are due on the first of day of each month.
Application Checklist

BEFORE YOU SUBMIT YOUR APPLICATION FORMS, REMEMBER TO:

- Complete and sign the Utah Individual Health Insurance Application Form
- Complete the Utah Individual Plans Supplemental Application Form
- Sign the Payment Selection Form
- OR visit us at selecthealth.org to apply online
SEP Addendum

Applicant’s Name ________________________________________________________________

Applicant’s Social Security OR Date of Birth __________________________________________

Are you:  ☐ A new applicant?  ☐ Adding dependents?  ☐ Changing an existing plan?

If you are enrolling outside of annual open enrollment or adding dependents, what is the reason? (documentation may be required)

☐ Loss of health plan coverage
☐ Loss of health plan coverage as result of a divorce
☐ Permanent move providing access to a new health plan
☐ Birth or adoption
☐ Marriage
☐ Court order
☐ Loss of Medicaid or CHIP eligibility
☐ Loss of cost-sharing eligibility tax credit
☐ Other ________________________________________________________________

Date of Event ________________________________________________________________

Will this coverage be replacing an existing Individual policy with SelectHealth?  ☐ Yes  ☐ No

If yes, enter policy number ______________________________________________________

eSignature ________________________________________________________________ Date ____________________