Fair Treatment Notice

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. Llame 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.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́'', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih SelectHealth: **1-800-538-5038**.

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नम्तिि भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । SelectHealth: **1-800-538-5038** मा फोन गर्नुहोस्।

FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he SelectHealth: **1-800-538-5038**.

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth: **1-800-538-5038**.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth: **1-800-538-5038**.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth: **1-800-538-5038**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth: **1-800-538-5038**

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم SelectHealth: **1-800-538-5038**.

សម្គាល់៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ សូវៅជំនួយផ្នែកភាសា ដាយមិនគិតថ្លៃ គឺអាចមានសំរាប់ អ្នក។ សូមទូរស័ព្ទមក SelectHealth: **1-800-538-5038** ។

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth: **1-800-538-5038**.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth: **1-800-538-5038**. まで、お電話にてご連絡ください。

selecthealth.

IDAHO INDIVIDUAL APPLICATION
FOR ENROLLMENT OUTSIDE OF THE IDAHO EXCHANGE

Please type or print legibly in black ink and complete all applicable sections.

SECTION 1 ENROLLMENT INFORMATION (check all that apply)

1. Are you: ☐ A new applicant ☐ Adding dependents ☐ Enrolling during the annual open enrollment
2. If you are enrolling ***outside*** of the annual open enrollment or adding dependents, what is the reason

   (documentation may be required)? ☐ Marriage ☐ Divorce ☐ Birth ☐ Adoption

   ☐ Involuntary loss of ***employer*** coverage ☐ Involuntary loss of ***individual*** coverage ☐ Involuntary loss of Medicaid

   ☐ Court order *(copy of court order required)* ☐ Other _____

   Date of event *(mm/dd/yyyy)* _____
3. The primary applicant and any spouse must be residents of the state of Idaho at the time of application and during the term of this policy to be eligible for coverage. Coverage under this policy will be terminated and this policy may be rescinded if residency within the state of Idaho is not maintained.

   Are you a resident of the state of Idaho? ☐ Yes ☐ No If yes:_____years _____months
4. Requested effective date *(Subject to approval): (mm/dd/yyyy)* _____

SECTION 2 APPLICANT INFORMATION

1. **Legal** First Name, Middle Name, Last Name *(and suffix, if applicable)*			
2. Street Address			
3. City	4. State	5. Zip Code	6. County
7. Mailing Address *(Street, Route, P.O. Box) (if different than street address)*			
8. City	9. State	10. Zip Code	11. County
12. Billing Address *(if different than mailing address)*			
13. City	14. State	15. Zip Code	16. County
17. Preferred **Daytime** Phone Number ( )	18. Alternate Phone Number ( )		19. Date of Birth *(mm/dd/yyyy)*
20. Gender ☐ Male ☐ Female	21. Social Security Number **(required)**	22. Marital Status ☐ Single ☐ Married ☐ Other _____	
23. Email Address			

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SECTION 3 — DEPENDENT INFORMATION

(List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required). If you have more dependents to include, make a copy of this page and attach.)

Dependent 1

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 1 live at the same address as you? ☐ Yes ☐ No		

Dependent 2

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 2 live at the same address as you? ☐ Yes ☐ No		

Dependent 3

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 3 live at the same address as you? ☐ Yes ☐ No		

Dependent 4

1. Legal First Name, Middle Name, Last Name *(and suffix, if applicable)*		2. Relationship ☐ **Legal** spouse ☐ Child ☐ Step-child ☐ Other _____
3. Gender ☐ Male ☐ Female	4. Date of Birth *(mm/dd/yyyy)*	5. Social Security Number **(required)**
6. Does dependent 4 live at the same address as you? ☐ Yes ☐ No		

SECTION 4 — OTHER INFORMATION

1. Are you or any dependent listed on this application receiving Worker's Compensation payments or are now eligible to receive such payments? ☐ **YES** ☐ **NO**
   If yes, give person's name, specific type and details: _____
   _____

2. Has any person listed on this application used a tobacco product on average four or more times a week within no longer than the past six months (anyone age 18 or older)? ☐ **NO** ☐ **YES** **If yes**, list names below:
   1. _____ 3. _____
   2. _____ 4. _____

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SECTION 5 OTHER COVERAGE INFORMATION *(Please complete the section below if you have other coverage that will remain in effect. If you have more policies to include, make a copy of this page and attach.)*

If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that the insurance carrier can determine whose coverage is primary.

Policy 1

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

2. Policy Holder Name		3. Names of Covered Members	
4. Types of Coverage *(check all that apply)* ☐ Group ☐ COBRA ☐ Individual ☐ HRP ☐ Medicare ☐ Medicaid ☐ Other _____	5. Coverage Start Date *mm/dd/yyyy*	6. Is this coverage terminating? ☐ Yes (complete #7) ☐ No	7. Coverage End Date *mm/dd/yyyy*

Policy 2

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

2. Policy Holder Name		3. Names of Covered Members	
4. Types of Coverage *(check all that apply)* ☐ Group ☐ COBRA ☐ Individual ☐ HRP ☐ Medicare ☐ Medicaid ☐ Other _____	5. Coverage Start Date *mm/dd/yyyy*	6. Is this coverage terminating? ☐ Yes (complete #7) ☐ No	7. Coverage End Date *mm/dd/yyyy*

SECTION 6 FEDERALLY ELIGIBLE INDIVIDUAL INFORMATION

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), guaranteed availability of individual coverage means that if you are HIPAA eligible, you cannot be denied the right to buy individual coverage. In addition, a preexisting condition exclusion cannot be applied to your coverage.

You are HIPAA eligible, also called an "eligible individual," if ALL of the following are true at the time you apply for individual coverage in Idaho.

- You are not covered under another group health plan
- Your most recent coverage was not canceled because you did not pay your premiums or because you committed fraud
- You are not currently eligible for Medicare or Medicaid

If you are HIPAA eligible, you will lose your right to get individual coverage without an exclusion unless you submit an application for individual coverage within 63 days after the day your group coverage or continuation coverage ends. Act promptly to protect your rights.

SECTION 7 AFFIRMATION

I affirm the answers in this "Idaho Individual Application" are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that the insurance carrier will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if I have made any misstatement or omission in this application, the insurance carrier may take any action available by law, including but not limited to, retroactive adjustment of premiums or claims. Further, I understand that any fraud or intentional misrepresentation of material fact in my completion of this application is cause for retroactive termination of coverage by the insurance carrier and/or other action available by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes an answer on this application incomplete or incorrect. Following receipt of a fully-executed application, coverage will be in force as of the effective date determined by the insurance carrier under applicable law.

SECTION 8 STATEMENT OF UNDERSTANDING

By signing this application, I represent that all my answers are complete and accurate to the best of my knowledge and belief and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the insurance carrier can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurance carrier may terminate or rescind an insured's coverage for any intentional misrepresentation, omission of fact by, concerning, or on behalf of any insured that was or would have been material to the insurance carrier's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- If this application is approved, coverage for me and any eligible persons named on this application will begin on the effective date assigned by the insurance carrier.
- I understand that this application will become part of the contract between the insurance carrier and me.
- I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.

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SECTION 9 PARENTAL OR GUARDIAN CONSENT TO APPLICATION

By completing this section and signing this application, I represent that the person listed as the applicant on this application is under 18 years of age and is making application for health coverage with my full knowledge and consent. I hereby accept full responsibility for the payment of premiums and the answers and information provided in this application.

Print Name	Date *(mm/dd/yyyy)*

Address *(if different than Dependent)*

SECTION 10 ACKNOWLEDGMENT

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the application) for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long-term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

Signature of Applicant _____ Signature Date *(mm/dd/yyyy)* _____

Signature of Spouse _____ Signature Date *(mm/dd/yyyy)* _____
(if applying for coverage)

SECTION 11 INDEPENDENT PRODUCER (AGENT) INFORMATION

Agent's Name _____ ID No._____

Signature of Agent _____ Date *(mm/dd/yyyy)* _____

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