Non-Discrimination Notice

SelectHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free aid and services to people with disabilities to help them communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). We also provide free language services to people whose primary language is not English, such as qualified interpreters and member materials written in other languages.

If you need these services, please call SelectHealth Member Services at **1-800-538-5038**. Any member or other person who believes he/she may have been subject to discrimination may file a complaint or grievance by calling the SelectHealth 504/Civil Rights Coordinator at **1-844-208-9012** 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**).

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Language Access Services

Spanish

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

Chinese

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**. 。

Vietnamese

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**.

Korean

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

번으로 전화해 주십시오.

Navajo

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

Nepali

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

Tongan

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**.

Serb-Croatian

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

Tagalog

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**.

German

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

Russian

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

Arabic

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

Mon-khmer, Cambodian

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

French

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

Japanese

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

selecthealth℠
BENEFIT ASSURANCE COMPANY

P.O. Box 30192 Salt Lake City, UT 84130-0192 800-538-5038 **selecthealth.org**

Utah Transition Plan Application

THIS IS A SHORT-TERM POLICY. IT PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE. THIS PLAN DOES NOT MEET THE MINIMUM ESSENTIAL COVERAGE REQUIREMENTS NEEDED TO AVOID THE INDIVIDUAL TAX PENALTY ASSOCIATED WITH THE AFFORDABLE CARE ACT (ACA).

A. APPLICANT INFORMATION Must be the oldest family member applying for coverage

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____ Unit# _____ Marital Status ❑ Single ❑ Legally Married

City _____ State_____ ZIP_____

Street Address (if different) _____

City _____ State_____ ZIP_____

Email Address _____ Home Ph#(_____)_____ Work Ph#(_____)_____

Payment Option (See Payment Selection Form, pg. 4) ❑ Single Payment ❑ Monthly Payment

B. APPLICANT AND DEPENDENT INFORMATION

IN THIS SECTION, LIST YOURSELF AND ANY ELIGIBLE FAMILY MEMBERS YOU WANT TO HAVE MEDICAL COVERAGE.

RELATIONSHIP	NAME (FIRST, MIDDLE INITIAL, LAST)	SEX (M/F)	DATE OF BIRTH (MM/DD/YY)	AGE	SOCIAL SECURITY# (FOR INTERNAL USE ONLY)
Self					
Spouse					
Child					
Child					
Child					
Child					
Child					
Child					
Child					

1. To be eligible for coverage, the applicant and all dependents must be younger than age 65. You cannot select a termination date later than the end of the month in which the applicant will turn 65.
2. To be eligible for coverage, children must be younger than age 26 (exceptions exist for disabled children older than age 26; please see your contract). Dependents who are not listed will not be considered for coverage. You cannot select a termination date later than the end of the month in which a dependent turns 26.

C. PRE-EXISTING CONDITION EXCLUSION NOTICE

The Transition plan does not cover any pre-existing conditions. We do not waive or credit pre-existing condition waiting periods on this plan, even if you had no break in coverage. The Transition plan defines pre-existing conditions as:

Any condition or symptom occurring within the two-year period preceding the effective date of coverage which would cause an ordinarily prudent person to seek diagnosis, care, or treatment; or a condition or symptom occurring in the two-year period preceding the effective date of coverage for which medical advice, care, or treatment was received from, or recommended by a physician; including but not limited to prescription and over-the-counter medication recommended by a provider.

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION.

D. PLAN INFORMATION

You have access to providers who participate on the Select Care® provider network. You must use participating providers and facilities to receive benefits for covered services unless otherwise noted in the contract.

Select a Medical Deductible and Coinsurance/Maximum Coinsurance amount:

MEDICAL DEDUCTIBLE	COINSURANCE AND MAXIMUM COINSURANCE
❑ $500 Individual/$1,500 Family	❑ 80%/20% – Maximum Coinsurance $1,000 per person
❑ $1,000 Individual/$2,500 Family	❑ 50%/50% – Maximum Coinsurance $2,500 per person
❑ $2,500 Individual/$5,000 Family	

E. EFFECTIVE DATE

Coverage is not in force until your application is approved and an effective date is determined by SelectHealth/SelectHealth Benefit Assurance Company (BAC). The minimum length of coverage is 30 days. The maximum length of coverage is 89 days. Coverage can start and end on any day of the month.

Coverage cannot begin until 31 days after your application is received by SelectHealth. You may request an effective date any time after the 31st day.

Requested Effective Date (optional) _____ **Requested End Date (optional)** _____

F. HEALTH INFORMATION

Answer each question and consider each individual applying for medical coverage. Fraud or intentional misrepresentation of material fact will result in the termination of your Plan.

❑ Yes ❑ No Will you, or any dependent to be covered, have any other health insurance coverage while this plan is in effect?

❑ Yes ❑ No Are you, or any dependent to be covered, currently eligible for Medicare, or will you or any dependent become eligible for Medicare during the term of coverage you are selecting?

❑ Yes ❑ No Are you, or any dependent to be covered (if one or more apply, check "Yes"):
- Currently pregnant or have reason to suspect you might be pregnant?
- Financially responsible for an unborn child or anticipating, applying for, or have applied for adoption?
- Male and weigh more than 300 pounds or female and weigh more than 250 pounds?

❑ Yes ❑ No Have you, or any dependent to be covered, ever been declined for health insurance due to health reasons?

❑ Yes ❑ No In the past 12 months, have you, or any dependent to be covered, been recommended to have, or been scheduled for, diagnostic testing, treatment, or surgery that has not been completed?

❑ Yes ❑ No Within the past two years, have you, or any dependent to be covered, had a problem for which medical advice hasn't been sought?

❑ Yes ❑ No Within the past five years, have you, or any other dependent to be covered, received any abnormal test results, medical or surgical treatment, healthcare professional consultation, or prescribed medication for any of these conditions?
- AIDS or tested positive for HIV
- Alcoholism, chemical dependency, drug or alcohol abuse
- Cancer or tumor
- Crohn's disease, ulcerative colitis, or hepatitis
- Diabetes
- Emphysema
- Heart disorder, including any heart-related symptoms
- Kidney disorder
- Stroke

G. GENERAL INFORMATION

1. Are you self-employed? ❑ Yes ❑ No

1a. If you are not self-employed, is any employer reimbursing or paying for any portion of this plan? ❑ Yes ❑ No

2. Does any listed eligible member live, reside, work, or attend school outside of Utah at any time during the year? ❑ Yes ❑ No

If you said "yes" to any of these questions, explain:

_____

_____

H. PRIOR COVERAGE INFORMATION

Are you, or any dependent to be covered, currently covered under any SelectHealth plan? ❑ Yes ❑ No

Have any applicants previously been covered under a SelectHealth Transition plan? ❑ Yes ❑ No

I. AUTHORIZATION AND ACKNOWLEDGMENT

The SelectHealth Transition plan is underwritten by SelectHealth BAC and administered by SelectHealth. I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with SelectHealth BAC. When incorporated with the Contract, this application and the Member Payment Summary (MPS) become part of the Contract. Once fully signed and executed, Plan and I agree to terms set forth in the Contract. In connection with both this Application and any Plan coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. Further, in dealing with SelectHealth/SelectHealth BAC, I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved by SelectHealth/SelectHealth BAC, that no benefits will be provided for any services that begin before the coverage is effective, and that except as expressly provided in the Contract, benefits will not extend beyond the termination of either my coverage or the Contract.

Consent at enrollment. I understand that no agent or Plan representative is allowed to permit me to answer any question inaccurately, untruthfully, or incompletely, and I represent that that did not occur.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration. I understand that my choice of healthcare providers whose services will be covered may be restricted by the Contract, and I agree that any services that are obtained without or contrary to required preauthorization/precertification requirements in the Contract may be denied. I understand the coverage for which I am applying may limit or exclude certain conditions and may exclude conditions for which a family member (including myself) has received any medical diagnosis or treatment or taken any medication or where symptoms were or should have been evident prior to his or her coverage effective date, according to the pre-existing conditions exclusion provisions of the Contract. I understand that this application will become part of the Contract.

Notice to applicant regarding replacement of accident and sickness insurance. According to information furnished, you may intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by SelectHealth/SelectHealth BAC. Your new policy provides a ten-day examination period within which you may decide whether you desire to keep the plan. There is a processing fee of $20 if you decide during the examination period that you will not keep the plan. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new plan:

1. Health conditions that you may presently have (pre-existing conditions) will not be covered under the new plan. This could result in a denial of a claim for benefits under the new plan, whereas a similar claim might have been payable under your present policy or plan.
2. You may wish to secure the advice of your current insurer or its agent regarding the proposed replacement of your current policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your current coverage.
3. If, after due consideration, you still wish to terminate (end) your current policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical or health history.
4. Failure to include all material medical information on an application may provide a basis for the Plan to deny any future claims and to refund your premium as though your plan had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

Pre-existing Conditions. I understand that any pre-existing condition or service rendered for a pre-existing condition, as defined on the first page of this application and in the Contract, is not covered by the Transition plan.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the health information on page two, is correctly recorded, true, and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. If I subsequently become aware of information different from that provided in this application, I agree to promptly provide that additional information to SelectHealth/SelectHealth BAC.

The policy provides limited benefits. Review your policy carefully.

J. SIGNATURE OF APPLICANT AND SPOUSE

Signature _____ Applicant Sign and Date Here **Date Signed** _____

Spouse's Signature _____ **Date Signed** _____
(required if applying for coverage)

K. AGENT/BROKER AGREEMENT (IF APPLICABLE)

I understand and agree that in acting as the agent/broker for this applicant:

1. The application was completed by the applicant.
2. I am in possession of a valid license issued by the state of Utah that authorizes me to sell and service health insurance contracts.
3. I have no authority to: a) make, alter, interpret, or discharge an application or Contract in the name of SelectHealth/SelectHealth BAC; or b) waive any of the terms or conditions of the Contract.
4. I have no authority to assign effective dates or to affect member changes.
5. Cancellation of this Healthcare Agreement by either the subscriber or SelectHealth/BAC will terminate this Agency Agreement.

SelectHealth received application

Agent Name _____ **Agency** _____ **Ph#(____)**_____

Agent's Signature _____ Agent/Broker Sign and Date Here **Date Signed** _____

Transition Plan Payment Selection Form

Applicant's Name _____ **Applicant's Social Security# OR Subscriber ID#** _____
(internal use only)

A. PAYMENT SELECTION

Please select one of the two 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.

❑ **Single Payment – Complete section "B" below.**
You choose both the start* and end date of coverage and pay for the entire plan in advance. If you end your plan early—by notifying SelectHealth in writing that you wish to end coverage—we will refund any over payment.

❑ **Monthly Payment – Complete section "C" below.**
SelectHealth will automatically withdraw premiums each month until a) you notify SelectHealth in writing that you wish to end your coverage, or b) you reach the maximum length of coverage.

*Coverage cannot begin until 31 days after your application is submitted.

B. SINGLE PAYMENT OPTION

You may pay your full premium using a credit/debit card or with an electronic check.

Credit/Debit Card
Select Card Type

❑ Visa ❑ MasterCard®
❑ Discover® ❑ American Express®

Card# _____
Expiration Date _____
Name on Card _____
Billing ZIP _____

Electronic Check
Account Holder's Name _____
Account Holder's ZIP _____
Account# _____
Financial Institution _____
Routing and Transit# _____

Cardholder's Signature _____ **Account Holder's Signature** _____

C. MONTHLY PAYMENT OPTION

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

I authorize SelectHealth to draw money from my ❑ **Checking Account** ❑ **Savings Account.**

Account Holder's Name _____ **Account#** _____

Financial Institution _____ **Routing and Transit#** _____

I understand that money will be drawn from my account on or about the 10th of each month, regardless of the policy effective date. I understand that I will be charged **$25** if the premium amount cannot be deducted from my account for any reason.

Account Holder's Signature _____

MONTHLY PAYMENT

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