SelectHealth, Inc.
P.O. Box 30192
Salt Lake City, UT 84130-0192
855-442-0220
selecthealth.org

Individual Plans Nevada Application Form

You can also enroll in a health insurance plan for you and your family through the Silver State Health Insurance Exchange (Nevada's state-based health insurance exchange). The Silver State Health Insurance Exchange allows you to get quotes from different insurance companies that are available on the Exchange. You can compare different plans, get quotes and find out if you qualify for financial assistance. The Silver State Health Insurance Exchange is the only way to receive financial assistance for your health insurance. You can enroll online by visiting www.nevadahealthlink.com or by calling 1-800-547-2927 TTY 711.

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

Last Name ______________________ First Name ______________________ Middle Initial __________

Street Address (No P.O. Box) ______________________ Unit# ________ Marital Status ❑ Single ❑ Married ❑ Domestic Partner

City ______________________ State______________________ ZIP______________________

Mailing Address (if different) ____

City ______________________ State______________________ ZIP______________________

Email Address ______________________ Home # (________)__________ Business Ph # (________)__________

Driver License # ______________________ Cell Phone #* ______________________

The primary applicant and any spouse must be residents of the state of Nevada at the time of applicaton 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 Coverage under this policy will be terminated and this policy may be rescinded if residency within the state of Nevada is not maintained.

Best way to contact you? ❑ Email ❑ Phone ❑ Mail   Are you a resident of Nevada? ❑ Yes ❑ No   Are you: ❑ A new applicant ❑ Adding dependents

DEMOGRAPHICS

Preferred Language** ❑ English ❑ Spanish ❑ Chinese ❑ Vietnamese ❑ Korean ❑ Navajo ❑ Nepali ❑ Tongan ❑ Serbo-Croatian ❑ Tagalog ❑ German ❑ Russian ❑ Arabic ❑ French ❑ Japanese ❑ Mon-Khmer, Cambodian ❑ Other ______________

Race ❑ White ❑ Black or African American ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Other

Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Citizenship ❑ United States Citizen ❑ Lawful Permanent Resident ❑ Temporary Visitor ❑ Undocumented Immigrant (for internal informational purposes only)

* By giving us your cell phone number and email address, you are giving us permission and consent to contact you using those channels
** By notifyiing us of your preferred language, we are not agreeing to send your materials in that language (for translation asistance, please call Member Services 800-538-5038)

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					

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION.

1. To be eligible for coverage, the applicant and all dependents must not be entitled to Medicare.
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).

Any applicants use tobacco? List: ____

Any applicants attend school or reside outside Nevada during year? List: ______________________

Any applicants have health care coverage, including Medicare or Medicaid? List: ______________________

C. MEDICAL PLAN INFORMATION

SELECT HEALTH®

PLANS WITH NO DEDUCTIBLE FOR OFFICE VISITS

The deductible is waived (only the copay applies) for all office visits.

- ❑ Select Health Value Gold 1000 Medical Deductible - no deductible for office visits
- ❑ Select Health Value Silver Copay Plan with 0 Medical Deductible
- ❑ Select Health Value Silver 6500 Health Deductible - no deductible for office visits
- ❑ Select Health Value Expanded Bronze 9200 Health Deductible - no deductible for office visits
- ❑ Select Health Med Gold 1000 Medical Deductible - no deductible for office visits
- ❑ Select Health Med Silver Copay with 0 Medical Deductible
- ❑ Select Health Med Silver 6500 Health Deductible - no deductible for office visits
- ❑ Select Health Med Expanded Bronze 9200 Health Deductible - no deductible for office visits

PLANS WITH NO DEDUCTIBLE FOR URGENT CARE AND ALL PRIMARY CARE PROVIDER (PCP AND MENTAL HEALTH OFFICE VISITS)

The deductible applies to all covered care except preventive care, which is covered no charge for all plans.

- ❑ Select Health Value Expanded Bronze 6900 Medical Deductible - no deductible for PCP or urgent care visits
- ❑ Select Health Med Expanded Bronze 6900 Medical Deductible - no deductible for PCP or urgent care visits

SELECT HEALTH HSA QUALIFIED*

The deductible applies to all covered care except preventive care.

- ❑ Select Health Value Expanded Bronze 8300 Health Deductible HSA Qualified
- ❑ Select Health Med Expanded Bronze 8300 Health Deductible HSA Qualified

Select Health designed the 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, Select Health makes no representations or warranties about the legal adequacy of this coverage as an Health Savings Account (HSA)-eligible plan. Select Health 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 Select Health 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.

D. SEP ADDENDUM

Applicant's Name ______________________________

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 Select Health? ❑ Yes ❑ No

If yes, enter policy number ______________________

Application Checklist

BEFORE YOU SUBMIT YOUR APPLICATION FORMS, REMEMBER TO:

- ☐ **Complete and sign the Individual Plans Application Form**
- ☐ **OR visit us at selecthealth.org to apply online**

Once you receive notification that your application has been approved, please call us at 855-442-0220 *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.*

- Your employer cannot pay any portion of you premium ieither directly or through reimbursement unless contributions are made through a qualified Health Reimbursement Arrangement (HRA)
- Select Health will only accept third-party premium payments when required by state or federal law

H. AGENCY/AGENT INFORMATION

NPN or Commission Entity ID ________________________ Phone ________________

Agency Name ____________________ Agent Name ______________________________

Sales Rep ____________________________ Effective Date________________

I. AUTHORIZATION AND ACKNOWLEDGMENT

This plan is underwritten and administered by Select Health. I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with Select Health. When incorporated with the Contract, this application and the Payment Summary 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 Select Health, 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 Select Health, 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.

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 this 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 requirements in the Contract may be denied.

I hereby declare that to the best of my knowledge and belief, the information given on this application 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 Select Health.

J. SIGNATURE OF APPLICANT

Signature ____ Date Signed ____________________