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

selecthealth.

# 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 Coverage under this policy will be terminated and this policy may be rescinded if residency within the state of Nevada is not maintained.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 ❑ English ❑ Spanish ❑ Chinese ❑ Vietnamese ❑ Korean ❑ Navajo ❑ Nepali ❑ Tongan ❑ Serbo-Croatian ❑ Tagalog ❑ German
Language** ❑ 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

* 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: _____

Is your employer reimbursing or paying for any portion of this policy? ❑ Yes ❑ No

## C. MEDICAL PLAN INFORMATION

### SELECTHEALTH® PLANS

**PLANS WITH NO DEDUCTIBLE FOR OFFICE VISITS**

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

- ❑ SelectHealth Value Gold 1000 - no deductible for office visits
- ❑ SelectHealth Value Silver Copay
- ❑ SelectHealth Value Silver 6500 - no deductible for office visits
- ❑ SelectHealth Value Expanded Bronze 9400 - no deductible for office visits
- ❑ SelectHealth Med Gold 1000 - no referrals or deductible for office visits
- ❑ SelectHealth Med Silver Copay with no referrals
- ❑ SelectHealth Med Silver 6500 - no referrals or deductible for office visits
- ❑ SelectHealth Med Expanded Bronze 9400 - no referrals or 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.***

- ❑ SelectHealth Value Expanded Bronze 6900 - no deductible urgent care/PCP office visits
- ❑ SelectHealth Med Expanded Bronze 6900 - no referrals or deductible urgent care/PCP office visits

**OFF EXCHANGE ONLY**

- ❑ SelectHealth Value Expanded Bronze 7000 - no deductible urgent care/PCP office visits
- ❑ SelectHealth Med Expanded Bronze 7000 - no referrals or deductible urgent care/PCP office visits

### SELECTHEALTH HSA QUALIFIED*

***The deductible applies to all covered care except preventive care.***

- ❑ SelectHealth Value Expanded Bronze 8000 HSA Qualified
- ❑ SelectHealth Med Expanded Bronze 8000 HSA Qualified

SelectHealth 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, SelectHealth makes no representations or warranties about the legal adequacy of this coverage as an Health Savings Account (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

**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.

## 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 SelectHealth? ❑ Yes ❑ No

If yes, enter policy number _____

# Individual Plans Payment Selection Form

Applicant's Name _____ Applicant's Social Security# OR Date of Birth _____
(internal use only)

## E. 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 (Complete Section "F.")

❑ Online Billing and Payment (Complete Section "G.")

## F. 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# _____

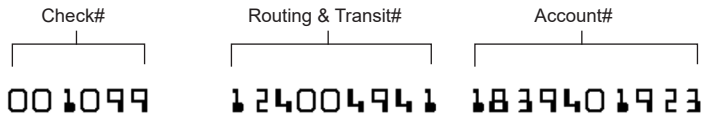
I understand that debit withdrawals will be submitted to my account on or about the 10th of each month, regardless of the policy effective date. I understand that a $25.00 service charge may be applied if the premium amount cannot be deducted from my account for any reason.

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.




## G. 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.

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# Application Checklist

**BEFORE YOU SUBMIT YOUR APPLICATION FORMS, REMEMBER TO:**

- ☐ **Complete and sign the Individual Plans Application Form**
- ☐ **Sign the Payment Selection Form**
- ☐ **<u>OR</u> visit us at selecthealth.org to apply online**

## 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 SelectHealth. I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with SelectHealth. 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 SelectHealth, 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, 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 SelectHealth.

## J. SIGNATURE OF APPLICANT

Signature _____ Date Signed _____