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

Individual Plans Colorado Supplemental Application Form

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

Cell Phone #* _____

A. DEMOGRAPHICS

Preferred Language** ❑ English ❑ Spanish ❑ Chinese ❑ Vietnamese ❑ Korean ❑ Nepali ❑ Persian (Farsi) ❑ Serbo-Croatian ❑ Tagalog ❑ German ❑ Russian ❑ Arabic ❑ French ❑ Japanese ❑ Thai ❑ Other _____

* By giving us your cell phone number and email address, you are giving us permission and consent to contact you using those channels
** By notifying 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. MEDICAL PLAN INFORMATION

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

Network Options ❑ Select Health Value

For more information, visit selecthealth.org/individualplans.

SELECT HEALTH PLANS

PLANS WITH NO DEDUCTIBLE FOR OFFICE VISITS

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

❑ Expanded Bronze 6900 – $6,900 Medical Deductible ($2,500 Rx Deductible)

❑ Silver 1500 – $1,500 Medical Deductible ($3,500 Rx Deductible)

❑ Silver 3200 – $3,200 Medical Deductible ($1,000 Rx Deductible)

❑ Gold 1500 – $1,500 Medical Deductible ($250 Rx Deductible)

❑ Gold 0 – $0 Medical Deductible ($1,000 Rx Deductible)

RX COPAY PLANS WITH COMBINED PHARMACY/MEDICAL DEDUCTIBLE

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

❑ Silver 6000 – $6,000 Medical and Rx Deductible combined

SELECT HEALTH HSA QUALIFIED

The deductible applies to all covered care except preventive care.

❑ Silver 3750 (HSA Qualified) – $3,750 Medical and Rx Deductible Combined (off exchange only)*

❑ Gold 1750 (HSA Qualified) - $1,750 Medical and Rx Deductible combined

Select Health designed the HSA-eligible 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. 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 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.

COLORADO OPTION PLANS

❑ Select Health Colorado Option Bronze

❑ Select Health Colorado Option Silver

❑ Select Health Colorado Option Silver Off Exchange

❑ Select Health Colorado Option Gold

Individual Plans Payment Selection Form

Applicant's Name _____ Applicant's Social Security# OR Date of Birth _____

C. PAYMENT SELECTION

Please select a method of payment for your monthly premium. Select Health® 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 "D.")*

❑ **Online Billing and Payment** *(Complete Section "E.")*

(internal use only)

D. 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 Select Health to initiate withdrawals from my ❑ **Checking Account** ❑ **Savings Account**

Account Holder's Name _____ Account# _____

Financial Institution _____ Routing & Transit# _____

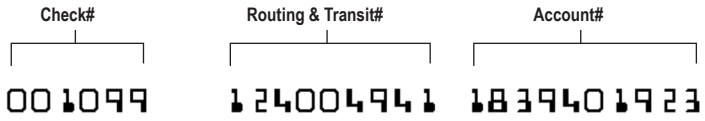
I understand that debit withdrawals will be submitted to my account on or about the 10th of each month, regardless of the policy effective date. I understand that a **$25.00 service charge** *may be applied if the premium amount cannot be deducted from my account for any reason.*

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.



E. 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.]*

[If you have selected the Online Billing and Payment option, complete and sign the agreement below. You will receive your monthly statement by Email. This Email will direct you to a website where you can make your monthly payment by debit or credit card. You can also set up automatic payments through the online payment website.

If you choose this method, your credit card will be charged for the first month's premium. Premium payments are due on the first day of each month.

***Credit/Debit Card** (for first month's premium **only**)*

❑ *Visa®* ❑ *Master Card®* ❑ *Discover®* ❑ *American Express®* Card # _____

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

Cardholider's Signature _____

Applicant's Signature _____ Applicant's Phone # _____

Email Adress _____ Applicant's Date of Birth _____]

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Select Health

Application Checklist

BEFORE YOU SUBMIT YOUR APPLICATION FORMS, REMEMBER TO:

- ☐ Complete and sign the Colorado Uniform Application For Major Medical Health Benefit Plans Form
- ☐ Complete the Colorado Individual Plans Supplemental Application Form
- ☐ Sign the Payment Selection Form
- ☐ **OR** visit us at selecthealth.org to apply online

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SEP Addendum

Applicant's Name _____

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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 _____

eSignature _____ **Date** _____