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

selecthealth.

Individual Plans Idaho Supplemental Application Form

Applicant's Name ________________________ **Applicant's Social Security# OR Date of Birth** ________________

Is this policy intended to replace any other accident and healthcare insurance presently in force? ❑ Yes ❑ No (internal use only)

DEMOGRAPHICS

Cell Phone #* ________________ Email Address ________________________

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

* 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)

PLAN OPTIONS

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

Network Options ❑ SelectHealth-SLHP ❑ BrightPath ❑ SAHA ❑ SelectHealth Med

SELECTHEALTH®

PLANS WITH NO DEDUCTIBLE FOR OFFICE VISTIS

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

- ❑ **Silver 4500** – $4,500 Medical Deductible ($2,500 Rx Deductible)
- ❑ **Gold 1500** – $1,500 Medical Deductible ($400 Rx Deductible)
- ❑ **Silver 3000** – $3,000 Medical Deductible ($1,500 Rx Deductible)
- ❑ **Silver 4000** – $4,000 Medical Deductible ($1,500 Rx Deductible)
- ❑ **Expanded Bronze 9400** – $9,400 Medical and Rx Deductible Combined
- ❑ **Expanded Bronze 6000** – $6,000 Medical Deductible ($2,000 Rx Deductible)
- ❑ **Gold 1000** – $1,000 Medical Deductible ($500 Rx Deductible)

$0 DEDUCTIBLE COPAY PLANS

- ❑ **Silver Copay Plan** – $0 Medical Deductible ($3,500 Rx Deductible)

TRADITIONAL DEDUCTIBLE PLANS

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

- ❑ **Bronze 8000** – $8,000 Medical Deductible ($1,700 Rx Deductible)
- ❑ **Expanded Bronze 4500** – $4,500 Medical Deductible ($1,700 Rx Deductible)

SELECTHEALTH HEALTHSAVE®

HSA-QUALIFIED PLANS*

The deductible applies to all covered care except preventive care

- ❑ **Expanded Bronze 8000 (HSA Qualified)** – $8,000 Medical Deductible and Rx Deductible Combined

SelectHealth® 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, SelectHealth makes no representations or warranties about the legal adequacy of this coverage as a Health Savings Account (HSA)-compatible 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 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 regardless of whether 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.**

PEDIATRIC DENTAL DISCLOSURE

The policy you are applying for does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Please contact your insurance agent or Your Health Idaho if you wish to purchase a stand-alone dental care product.

selecthealth.

Individual Plans Payment Selection Form

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

A. PAYMENT SELECTION

Please select a payment method 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 "B")

❑ **Online Billing and Payment**
(Complete Section "C")

B. 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 one of the following ❑ **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 service charge** will be applied if the premium amount cannot be deducted from my account for any reason.

Account Holder's Signature ______________________ **Date** ______________________

C. 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 Checkoff List

BEFORE YOU SUBMIT YOUR APPLICATION FORMS, REMEMBER TO:

- ☐ **Complete and sign the Idaho Individual Health Insurance Application Form**
- ☐ **Complete the Idaho 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 ____

Applicant's Social Security OR Date of Birth ____

Are you: ☐ A new applicant? ☐ Adding dependents? ☐ Changing an existing plan?

Are you enrolling: ☐ During the annual open enrollment period? ☐ Outside of annual open enrollment period?

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 ____

eSignature ____ **Date** ______________________