

Individual Plans Utah Supplemental Application Form

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

A. DEMOGRAPHICS

Cell Phone #* _____

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 notifying us of your preferred language, we are not agreeing to send your materials in that language (for translation assistance, 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 Select Health Med Select Health Signature

For more information, visit selecthealth.org/individualplans.

SELECT HEALTH®

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 (\$1,500 Rx Deductible) (Value Network Only)
- Silver 5500 (Off-Exchange Only) – \$5,500 Medical Deductible (\$1,500 Rx Deductible)*
- Gold 1500 – \$1,500 Medical Deductible (\$250 Rx Deductible)*
- Benchmark Silver 5900 – \$5,900 Medical Deductible (\$900 Rx Deductible)
- Silver 3000 – \$3,000 Medical Deductible (\$1,000 Rx Deductible) (Value Network Only)

PLANS WITH \$0 DEDUCTIBLES

- Benchmark Expanded Bronze Copay plan – \$0 Medical Deductible (\$3,500 Rx Deductible) (Med and Value Network Only)
- Benchmark Platinum - \$0 Medical Deductible (\$0 Rx Deductible)*
- Benchmark Gold - \$0 Medical Deductible (250 Rx Deductible)* (Signature Network Only)

SELECT HEALTH HSA QUALIFIED

The deductible applies to all covered care except preventive care.

- Expanded Bronze 8050 (HSA Qualified) – \$8,050 Medical and Rx Deductible Combined (Med Network Only)
- Benchmark Silver 3750 (HSA Qualified) – \$3750 Medical and Rx Deductible Combined (off exchange only)*

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. 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.**

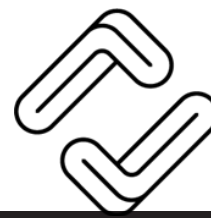
HSA VENDOR

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.

* Can be paired with the Signature Network



E. 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.

| Check# | Routing & Transit# | Account# |
|---------|--------------------|---------------|
| 00 1099 | 1 2400494 1 | 18 3940 19 23 |

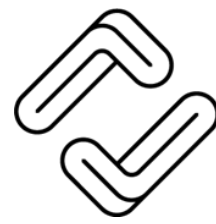
F. ONLINE BILLING AND

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.

Application Checklist

BEFORE YOU SUBMIT YOUR APPLICATION FORMS, REMEMBER TO:

- Complete and sign the Utah Individual Health Insurance Application Form
- Complete the Utah Individual Plans Supplemental Application Form
- Sign the Payment Selection Form
- OR** visit us at selecthealth.org to apply online



SEP Addendum

Applicant's Name _____

Applicant's Social Security OR Date of Birth _____

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 _____