selecthealth℠
AN INTERMOUNTAIN HEALTHCARE COMPANY

selecthealth℠
BENEFIT ASSURANCE COMPANY

4646 West Lake Park Boulevard, Salt Lake City, UT 84120-8212 1-801-442-5038/1-800-538-5038 www.selecthealth.org

Enrollment Form and Instructions

You must read the back of this Enrollment Form before signing it. It contains further instructions and terms for agreement.

All areas should be completed in detail by you and your employer. It is your responsibility to read and understand this information and follow the instructions. Please print clearly. Enrollment Forms that are unreadable or incomplete will delay processing.

These instructions will help you complete the Enrollment Form. If you need more help, contact a Human Resources/Personnel representative at your place of employment or Member Services at 1-801-442-5038 (Salt Lake area) or 1-800-538-5038.

SECTION A: EMPLOYEE INFORMATION

Complete this section with all of the requested information about yourself (the employee applying for coverage).

SECTION B: EMPLOYEE & DEPENDENT INFORMATION

Complete this section with all of the requested information about you and your dependent(s).

- If your dependent child is over the age limit specified in the agreement with SelectHealth℠/SelectHealth Benefit Assurance Company℠ (SelectHealth BAC) and your employer, but still eligible for coverage under the Plan because of a physical or mental disability, you must attach proof of the dependent's disability to this form.
- You must list other health insurance (not dental) information for each person listed on this form in order for SelectHealth/SelectHealth BAC to coordinate benefits with other carriers when necessary. List the name of the member to be covered, name and phone number of the other health insurance carrier, the policy effective and termination date, the policyholder name, and the member's Social Security number.
- If you or your eligible dependents have had health insurance coverage within the last 63 days, your Pre-Existing Condition Waiting Period (if applicable) may be partially or completely waived. You must give SelectHealth/SelectHealth BAC proof of prior coverage, such as a Certificate of Creditable Coverage, ID Card, Explanation of Benefits (EOB), etc., for each applicant. You have the right to request a Certificate of Creditable Coverage from your prior plan. If necessary, SelectHealth/SelectHealth BAC will assist in obtaining such certificates.

If your spouse is added, he or she may only be deleted from your coverage in the following circumstances:

- During your employer's next annual open enrollment period; or
- When proof of a legal divorce or annulment is given to SelectHealth/SelectHealth BAC; or
- When your spouse agrees by signing the SelectHealth Employee Change Form (if allowed by your employer's eligibility rules).

SECTION C: EMPLOYEE AGREEMENT & SIGNATURE

You must read the back of this Enrollment Form to complete this section. If you read, understand, and agree to the terms stated in "Section C" on the back, sign the front of the Enrollment Form under "Section C: Employee Agreement & Signature."

SECTION D: WAIVER OF COVERAGE

Complete and sign this section if you wish to waive healthcare coverage at this time.

You and your dependents may not be eligible to enroll in this program again until the next annual open enrollment period established by your employer and SelectHealth/SelectHealth BAC unless you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance coverage. You may, in the future, be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse, and any dependent child(ren) newly acquired by such marriage, birth, adoption, or placement for adoption if you request enrollment within 31 days after the marriage or the date of birth, adoption, or placement for adoption.

SECTION E: QUALIFICATION OF COVERAGE

(To be completed by your employer)

- **Read the instructions in "Section E" on the back of the Enrollment Form.**

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Are you (Please check one):

❑ A new enrollee
❑ Switching from another SelectHealth plan (list plan) _______________
❑ Switching from another carrier (list carrier)_________________________

Please check a health plan below. Form is not complete unless a box is checked!
❑ Select Care(SM) ❑ Select Med(SM) ❑ Select Value(SM) ❑ Select Care Plus(SM) ❑ Select Med Plus(SM)
❑ Select Choice Premier(SM)* ❑ Select Choice(SM)*
*Benefits are administered by SelectHealth and underwritten (insured) by SelectHealth Benefit Assurance Company.

SECTION A: EMPLOYEE INFORMATION (Please print clearly)

Employee Name (Last, First, Initial) ____ Employer Name _____________________________________

Mailing Address ____ Full-Time Hire Date _______________ Hours Worked Weekly ____________

City _______________________________ State _________ ZIP ____________ E-mail Address ____

Home Phone# ______________ Work Phone# ______________ Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced

Application for medical benefits (and dental as authorized by employer group) for:
❑ Myself ❑ Myself and my dependent children only **(no spouse)** ❑ Myself and my legal spouse only
❑ Myself, legal spouse, and dependent children

Are you enrolling because of a special enrollment event? ❑ Yes ❑ No
If yes, check all that apply ❑ Birth/adoption ❑ Marriage ❑ Loss of other coverage

Carrier ____ Date coverage began _______________ Date coverage ended _____________
You must give proof of prior coverage to SelectHealth/SelectHealth BAC as soon as reasonably possible.

Are you adding a dependent because of a court or administrative order? ❑ Yes ❑ No
If yes, please attach a copy of the notice with this form.

SECTION B: EMPLOYEE AND DEPENDENT INFORMATION

Complete this section in full. List yourself and all eligible dependents (spouse and children) you wish to be covered. Children must be unmarried and dependent on you for their support. List children in order of age. List the relationship of all children and dependents to the employee in the "Relationship" column. If you need more space, use another Enrollment Form (available from SelectHealth/SelectHealth BAC).

	NAME OF MEMBER TO BE COVERED (LAST, FIRST, MIDDLE INITIAL)	SEX M	SEX F	BIRTH DATE (MM/DD/YY)	RELATIONSHIP	SOCIAL SECURITY#
1	YOURSELF					
2						
3						
4						
5						

Are you and/or your ex-spouse required to pay your dependent's medical expenses in a divorce decree? ❑ Yes ❑ No
If yes, you must attach a copy of the divorce decree with this Enrollment Form. You should include the first page of the decree, the signature page, and any other portion(s) of the decree that specifies responsibility for dependent coverage.

Will you have other health insurance in addition to this plan? ❑ Yes ❑ No (If yes, complete below)

	MEMBER TO BE COVERED	CARRIER	PHONE#	POLICY EFFECTIVE DATE	POLICYHOLDER NAME
1					
2					
3					

SECTION C: EMPLOYEE AGREEMENT AND SIGNATURE

This section requires that you turn to the back of this form and read the information in "Section C: Employee Agreement & Signature." I hereby certify that I have read, understand, and agree to the terms outlined in "Section C: Employee Agreement & Signature" on the reverse side of this Enrollment Form. After your employer has checked and approved this form, please keep a copy for your records.

Employee Signature ____ Date _______________________________________

SECTION D: WAIVER OF COVERAGE

I have been given the opportunity to enroll and choose to waive such coverage. I have read the information in "Section D" on the front of this Enrollment Form and understand the consequences of my choice to waive coverage. Reason for waiving: (check one box)

❑ I already have health insurance through ___________________________________ ____
(Insurance Company Name) Employee Signature
❑ I do not want to buy any health insurance at this time.

SECTION E: EMPLOYER USE ONLY (Employer, please provide the following information where applicable to this employee)

If using HealthEquity (SelectHealth's preferred vendor) for HSA account administration, check the following box:
❑ Health Savings Account (HSA)

PEC Waiting Period ______________________ (Date) through ____________ (Date) Subgroup Name __________________Class Name _________________

Employee's Current Payroll Status _______________________________ Employee's Plan Effective Date _________________________________

Comments ____ Employer's Signature ______________________Date _______________

LG-UT Enroll 10/01/06

Enrollment Form

You and your employer must complete all areas in detail. It is your responsibility to read and understand this information and follow the instructions. Please print clearly.

The following instructions will answer most questions. If you need assistance, please contact a Human Resources/Personnel representative at your place of employment or Member Services at 1-801-442-5038 (Salt Lake area) or 1-800-538-5038.

- After your employer has checked and approved this form, please keep a copy for your records.

SECTION C: EMPLOYEE AGREEMENT & SIGNATURE

You must read and understand the following information. After you have read and agreed to the following terms of this form, turn to the front of this Enrollment Form and sign under "Section C: Employee Agreement & Signature." Otherwise, this application and enrollment may not be valid.

- I hereby apply for membership in SelectHealth[SM]/SelectHealth BAC[SM] for the persons listed on this application (herein referred to as applicants) and agree to submit premiums as required by SelectHealth/SelectHealth BAC or authorize my employer to deduct from my earnings the necessary contributions, if any, required of me. I accept the terms of the group agreement between my employer and SelectHealth/SelectHealth BAC and appoint my employer to act as an agent on my behalf. I understand that said agreement is on file with the employer and SelectHealth/SelectHealth BAC and is available for my inspection. I understand that any intentional material misrepresentation in answering the questions on this application or nonpayment of premiums, deductibles, or copays/coinsurance may result in recision or cancellation of my coverage and that of my dependents.

SECTION E: EMPLOYER USE ONLY

An authorized representative of the employer group must complete this section. NOTE: The first two items below only apply if employees are to be credited for previously satisfied Pre-Existing Condition Waiting Periods.

- Employee's Current Payroll Status – Indicates the current employment classification of the subscriber. Note, for example, if he or she is an active employee, on an approved leave of absence, retired, etc.
- Comments – This section may be used to communicate any other pertinent information to SelectHealth/SelectHealth BAC.
- Employer's Signature – A representative of the employer must sign and date this section to validate the form.