Are you (Please check one):

- ❑ A new enrollee
- ❑ Switching from another SelectHealth plan (list plan) _____
- ❑ Switching from another carrier (list carrier) _____

Select Med℠

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 account administration, employees must complete the HSA Enrollment & Authorization to Disclose Health Information to HealthEquity Form.

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 _____

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℠/SelectHealth BAC℠ 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.