

New Group Data Summary Small Employer

Use this form for new group submissions only.

Company Name _____
Street Address _____
City _____ State _____ ZIP _____ Ph# (_____) _____
Company Key Contact _____ Company Fax# (_____) _____
Billing Address (If different than above, e.g., P.O. Box) _____ Billing Contact _____
City _____ State _____ ZIP _____ Billing Ph# (_____) _____
Proposed Effective Date _____ Writing Agent/Broker Name _____ Ph# (_____) _____
General Agency (GA) Affiliation, if applicable _____
Name of current group carrier, if applicable _____ Coverage dates: From _____ To _____
Reason for changing carriers Rate increase Poor service Benefits Other _____
Federal tax ID# _____ Number of years in business _____
Employer contribution amount — \$ amount OR % amount (minimum 50%) Employee _____
Total number of full-time employees now _____ Total number of full-time employees one year ago _____
Are any employees eligible for or on COBRA or Utah mini-COBRA? Yes No (If yes, each employee must submit a completed Employee Application)
Have all employees completed and signed their own application? Yes No Employer Initials _____ Agent/Broker Initials _____
Payment method Preauthorized Banking Withdrawal Web Pay Monthly Payment (add \$25 monthly administration fee)

A. OPEN PANEL (If you are selecting any other medical plan, leave this section blank)

SELECT FROM THESE OPTIONS FOR OPEN PANEL:

Medical Deductible Option \$250 \$500 \$1,000 \$2,000

Coinsurance and Copay (PCP/SCP) 80%/20% 80%/20%
\$25/\$40 \$35/\$50

Deductible for Office Visits/Prescription Drugs Waiver of Deductible for Office Visits — Select **one** of the two prescription drug options below:
 Rx Deductible Waiver Rx Deductible* (per person/calendar year)
 No Waiver of Deductible for Office Visits or Rx

Maternity Option Covered as any other illness Separate \$7,500 maternity deductible, per pregnancy (required for groups with 15+ employees)

Mental Health Option Standard (50%/50%) Parity (required for groups with 51+ employees) Catastrophic

Supplemental Accident Option Yes No

***If your Medical Deductible is:** \$250 \$500 \$1,000 \$2,000
Your Rx Deductible is: \$150 \$250 \$500 \$1,000

Tier 1 drugs (primarily generic drugs) are covered before the Rx deductible on all plans.

B. SELECTHEALTH DENTAL (Available with all plans)

Dental Deductible \$0 \$50 \$100

Annual Maximum Benefit \$1,000 \$1,500 \$2,000

Orthodontics (for contributory plans with at least five enrolling employees only) Yes No
If yes, choose lifetime maximum \$1,000 \$1,500

Nonparticipating Coinsurance (Traditional is 80% preventive/60% basic/40% major) Upgrade to 100% preventive/80% basic/50% major

Prior Coverage Yes, with orthodontics Yes, without orthodontics No

Employer Contribution Contributory (50% or more is required) Voluntary

C. HEALTHSAVE PLAN (If you are selecting any other medical plan, leave this section blank)

SELECT FROM THESE OPTIONS FOR HEALTHSAVE

Deductible Option (Single/Family)

Coordinating Out-of-Pocket Maximum

- | | | |
|----------------------------|------------------|------------------|
| <input type="checkbox"/> 1 | \$1,200/\$2,400 | \$3,600/\$7,200 |
| <input type="checkbox"/> 2 | \$1,500/\$3,000 | \$5,000/\$10,000 |
| <input type="checkbox"/> 3 | \$2,500/\$5,000 | \$3,500/\$7,000 |
| <input type="checkbox"/> 4 | \$5,000/\$10,000 | \$5,000/\$10,000 |

- Maternity Option** Covered as any other illness (required for groups with 15+ employees) Not covered
- Mental Health Option** Standard (50%/50%) Parity (required for groups with 51+ employees) Catastrophic
- Health Savings Account** Yes* No

**By choosing yes, you have selected to use HealthEquity®, SelectHealth's preferred vendor for HSA administration. Account fee is \$2.25 per account holder per month and will be included on your monthly bill.*

D. DUAL OPTION PLAN (If you are selecting any other medical plan, leave this section blank)

SELECT FROM THESE OPTIONS FOR DUAL OPTION

OPTION

HEALTHSAVE PLAN

TRADITIONAL PLAN

- | | | |
|----------------------------|--|---|
| <input type="checkbox"/> 1 | Select Care Plus SM HealthSave
\$1,500/\$3,000 Ded., 20% Coins., \$25/\$40 Copay | Select Value [®]
\$250/\$750 Ded., 20% Coins., \$25/\$40 Copay |
| <input type="checkbox"/> 2 | Select Care Plus HealthSave
\$1,500/\$3,000 Ded., 20% Coins., \$25/\$40 Copay | Select Med Plus [®]
\$500/\$1,000 Ded., 20% Coins., \$35/\$50 Copay |
| <input type="checkbox"/> 3 | Select Med Plus HealthSave [®]
\$1,500/\$3,000 Ded., 20% Coins., \$25/\$40 Copay | Select Med Plus
\$1,000/\$2,000 Ded., 20% Coins., \$35/\$50 Copay |
| <input type="checkbox"/> 4 | Select Care Plus HealthSave
\$1,500/\$3,000 Ded., 20% Coins., \$25/\$40 Copay | Select Med Plus
\$1,000/\$2,000 Ded., 20% Coins., \$25/\$40 Copay |
| <input type="checkbox"/> 5 | Select Care Plus HealthSave
\$1,500/\$3,000 Ded., 20% Coins., \$25/\$40 Copay | Select Med Plus
\$1,000/\$2,000 Ded., 20% Coins., \$25/\$40 Copay |
| <input type="checkbox"/> 6 | Select Care Plus HealthSave
\$1,500/\$3,000 Ded., 20% Coins., \$25/\$40 Copay | Select Care Plus
\$1,000/\$2,000 Ded., 20% Coins., \$35/\$50 Copay |
| <input type="checkbox"/> 7 | Select Care Plus HealthSave
\$2,500/\$5,000 Ded., 20% Coins., \$25/\$40 Copay | Select Med Plus
\$1,000/\$2,000 Ded., 20% Coins., \$25/\$40 Copay |

- Mental Health Option** Standard (50%/50%) Parity (required for groups with 51+ employees) Catastrophic
- Health Savings Account** Yes No

By choosing yes, you have selected to use HealthEquity, SelectHealth's preferred vendor for HSA administration. Account fee is \$2.25 per account holder per month and will be included on your monthly bill.

E. DUAL CARRIER PLAN (If you are selecting any other medical plan, leave this section blank)

SELECT FROM THESE OPTIONS FOR DUAL CARRIER

- Medical Deductible Option** \$250 \$500 \$1,000 \$1,500 \$2,500 \$4,000
- Maternity Option** Covered as any other illness (required for groups 15+) Separate \$7,500 maternity deductible
- Mental Health Option** Standard (50%/50%) Catastrophic

F. NETCARE PLAN (If you are selecting any other medical plan, leave this section blank)

SELECT FROM THESE OPTIONS FOR NETCARE

Deductible Option (Single/Family)

Coordinating Out-of-Pocket Maximum

- | | | |
|----------------------------|------------------|-------------------|
| <input type="checkbox"/> 1 | \$1,500/\$4,500 | \$5,000/\$15,000 |
| <input type="checkbox"/> 2 | \$3,500/\$10,500 | \$10,000/\$30,000 |

- Mental Health Option** Standard (70%/30%) Parity (required for groups with 51+ employees) Catastrophic

F. SIGNATURE

Employer Signature _____ Date _____

Agent/Broker Signature _____ Date _____