

## Transition<sup>SM</sup> Plan Application Form

### A. APPLICANT INFORMATION (Must be oldest family member applying for coverage)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Mailing Address \_\_\_\_\_ Unit# \_\_\_\_\_ Marital Status  Single  Legally Married  Separated  Divorced

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Street Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Your Occupation \_\_\_\_\_ Your Spouse's Occupation \_\_\_\_\_

E-mail Address \_\_\_\_\_ Home Ph#(\_\_\_\_) \_\_\_\_\_ Work Ph#(\_\_\_\_) \_\_\_\_\_

Payment Option (See Payment Selection Form, p. 4)  Single Payment  Monthly Payment

### B. APPLICANT AND DEPENDENT INFORMATION

IN THE SECTION BELOW, LIST YOURSELF AND ELIGIBLE FAMILY MEMBERS TO BE INCLUDED UNDER MEDICAL COVERAGE.

RELATIONSHIP	NAME (FIRST, MIDDLE INITIAL, LAST)	SEX (M/F)	DATE OF BIRTH (MM/DD/YY)	AGE	SOCIAL SECURITY# (FOR INTERNAL USE ONLY)
Self					
Spouse					
Child					
Child					
Child					
Child					
Child					
Child					
Child					
Child					

- To be eligible for coverage, the applicant and all dependents must be younger than age 65. You cannot select a termination date later than the end of the month in which the applicant will turn 65.
- To be eligible for coverage, children must be younger than age 26, unmarried, and dependent upon you for 50 percent of their financial support. (Financial dependency is not required for court-ordered dependent coverage.) Any dependent not listed will not be considered for coverage. You cannot select a termination date later than the end of the month in which a dependent turns 26.
- Infants are eligible after they have had their first routine checkup (usually two weeks).
- Once the application is accepted by SelectHealth, you will not be able to add or remove dependents during the plan term.

### C. PRE-EXISTING CONDITION EXCLUSION NOTICE

Please note that all pre-existing conditions are excluded under the Transition plan. No pre-existing waiting period credit is given for previous coverage, regardless of whether or not there is a break in coverage. Pre-existing conditions are defined in the Transition plan Contract as follows:

*A Pre-Existing Condition is any condition or symptom occurring within the two-year period preceding the effective date of coverage which would cause an ordinarily prudent person to seek diagnosis, care, or treatment; or a condition or symptom occurring in the two-year period preceding the effective date of coverage for which medical advice, care, or treatment was received from, or recommended by a physician; including but not limited to prescription and over-the-counter medication recommended by a provider.*

### SELECTHEALTH USE ONLY

Class# \_\_\_\_\_ Plan \_\_\_\_\_ Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_

Agent/Broker \_\_\_\_\_ Agent/Broker# \_\_\_\_\_

Rate Adjustment Percent \_\_\_\_\_ Monthly Payment \$ \_\_\_\_\_ PEC \_\_\_\_\_

Notes \_\_\_\_\_

**D. PLAN INFORMATION**

You can use any provider for covered services, but you are protected from a balance bill when you use providers who participate on the Select Care provider network. The logo that will appear on your ID Card is:



Select a Medical Deductible and Coinsurance/Maximum Coinsurance amount below.

**MEDICAL DEDUCTIBLE**

- \$250 Individual/\$750 Family
- \$500 Individual/\$1,500 Family
- \$1,000 Individual/\$2,500 Family
- \$2,500 Individual/\$5,000 Family

**COINSURANCE & MAXIMUM COINSURANCE**

- 80%/20% - Maximum Coinsurance \$1,000 per person
- 50%/50% - Maximum Coinsurance \$2,500 per person

**E. HEALTH INFORMATION**

Instructions: Answer each question considering each individual applying for medical coverage. If the answer to any of these questions is "yes," you will not be eligible for coverage on the Transition plan.

- Yes  No Do you, or any dependent to be covered, have any other health insurance coverage?
- Yes  No Are you, or any dependent to be covered, currently eligible for Medicare, or will you or any dependent become eligible for Medicare during the term of coverage you are selecting?
- Yes  No Are you, or any dependent to be covered, currently pregnant, or have reason to suspect you might be pregnant?
- Yes  No Are you, or any dependent to be covered, financially responsible for an unborn child, anticipating adoption, applying for, or have applied for adoption?
- Yes  No Have you, or any dependent to be covered, ever been declined for health insurance due to health reasons?
- Yes  No In the past 12 months, have you, or any dependent to be covered, been recommended to have, or been scheduled for, diagnostic testing, treatment, or surgery that has not been completed?

**F. EFFECTIVE DATE**

Coverage is not in force until your application is approved and an effective date is determined by SelectHealth/SelectHealth Benefit Assurance Company (BAC). The minimum length of coverage is one full month. The maximum length of coverage is six months. Coverage can start on any day of the month but must end on the last day of a month. A partial first month of coverage will count as one full month for the purpose of determining maximum length of coverage.

The start date must be within one month of the date the application is signed and will be the later of:

- the day after the completed application is received by SelectHealth, or
- the effective date listed on the application.

**Requested Effective Date** \_\_\_\_\_ **Requested End Date (Single payment option only)** \_\_\_\_\_  
(Must be last day of a month)

**G. GENERAL INFORMATION**

- 1. Are you self-employed?..... **Y N**
- 1a. If you are not self-employed, is any employer reimbursing or paying for any portion of this plan? ..... **Y N**
- 2. Does any listed proposed member live, reside, work, or attend school outside of Utah at any time during the year?..... **Y N**

Please explain "yes" answers to the above questions

\_\_\_\_\_

**H. PRIOR COVERAGE INFORMATION**

Have you had health insurance coverage within the past 63 days?  Yes  No

If "Yes," list carrier \_\_\_\_\_

**I. AUTHORIZATION AND ACKNOWLEDGMENT**

The SelectHealth Transition plan is underwritten by SelectHealth BAC, and administered by SelectHealth. I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with SelectHealth BAC. When incorporated with the Contract, this application and the Member Payment Summary (MPS) become part of the Contract. Once fully signed and executed, Plan and I agree to terms set forth in the Contract. In connection with both this Application and any Plan coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. Further, in dealing with SelectHealth/SelectHealth BAC, I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved by SelectHealth/SelectHealth BAC, that no benefits will be provided for any services which begin before the coverage is effective, and that except as expressly provided in the Contract, benefits will not extend beyond the termination of either my coverage or the Contract.

**Consent at enrollment.** I understand that no agent or Plan representative is allowed to permit me to answer any question inaccurately, untruthfully, or incompletely, and I represent that such did not occur.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration. I understand that my choice of healthcare providers whose services will be covered may be restricted by the Contract, and I agree that any services which are obtained without or contrary to required preauthorization/precertification requirements in the Contract may be denied coverage. I understand the coverage for which I am applying may limit or exclude certain conditions and may exclude conditions for which a family member (including myself) has received any medical diagnosis or treatment or taken any medication or where symptoms were or should have been evident prior to his or her coverage effective date, according to the pre-existing conditions exclusion provisions of the Contract. I understand that this application will become part of the Contract.

**Notice to applicant regarding replacement of accident and sickness insurance.** According to information furnished, you may intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by SelectHealth/SelectHealth BAC. Your new policy provides a ten-day examination period within which you may decide whether you desire to keep the plan. There is a processing fee of \$20 if you decide during the examination period you will not keep the plan. For your own information and protection, you should be aware of and seriously consider certain factors, that may affect the insurance protection available to you under the new plan.

1. Health conditions which you may presently have (pre-existing conditions) will not be covered under the new plan. This could result in a denial of a claim for benefits under the new plan, whereas a similar claim might have been payable under your present policy or plan.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical or health history.
4. Failure to include all material medical information on an application may provide a basis for the Plan to deny any future claims and to refund your premium as though your plan had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

**Pre-Existing Conditions.** I understand that any pre-existing condition or service rendered for a pre-existing condition, as defined on the first page of this application and in the Contract, is not covered by the Transition plan.

**I hereby declare that to the best of my knowledge and belief, the information given on this application, including the health information on page two, is correctly recorded, true, and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. If I subsequently become aware of information different from that provided in this application, I agree to provide that additional information promptly to SelectHealth/SelectHealth BAC.**

**J. SIGNATURE OF APPLICANT AND SPOUSE**

Signature \_\_\_\_\_ *Applicant Sign and Date Here* \_\_\_\_\_ Date Signed \_\_\_\_\_

Spouse's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_  
*(Required if applying for coverage)*

**K. AGENT/BROKER AGREEMENT (IF APPLICABLE)**

I understand and agree that in acting as the agent/broker for this applicant:

1. The application was completed by the applicant;
2. I am in possession of a valid license issued by the state of Utah that authorizes me to sell and service health insurance contracts;
3. I have no authority to: a) make, alter, interpret, or discharge an application or Contract in the name of SelectHealth BAC; or b) waive any of the terms or conditions of the Contract.
4. I have no authority to assign effective dates or to affect member changes.
5. Cancellation of this Healthcare Agreement by either the subscriber or SelectHealth BAC will terminate this Agency Agreement.

Date application received at SelectHealth, Inc.

Agent/Broker Name \_\_\_\_\_ Agency \_\_\_\_\_ Ph#(\_\_\_\_) \_\_\_\_\_

Agent Signature \_\_\_\_\_ *Agent/Broker Sign and Date Here* \_\_\_\_\_ Date Signed \_\_\_\_\_

# Transition Plan Payment Selection Form

Applicant's Name \_\_\_\_\_ Applicant's Social Security# OR Subscriber ID# \_\_\_\_\_  
(internal use only)

## A. PAYMENT SELECTION

Please select one of the two available methods of payment for your monthly premium. **Your employer cannot** pay any portion of your premium, either directly or through reimbursement. Submit only personal account information.

**Single Payment - Complete section B below.**

You select both the start and end date of coverage and pay for the entire plan term in advance.

**Monthly Payment - Complete section C below.**

You select a start date and pay your first month's premium in advance. SelectHealth will automatically withdraw premium each month until: a) you notify SelectHealth in writing you wish to terminate your coverage, or b) you reach the maximum six months of coverage.

## B. SINGLE PAYMENT OPTION

You may pay your full premium using a credit/debit card or with an electronic check.

### Credit/Debit Card

Select Card Type

- Visa       MasterCard®  
 Discover®     American Express®

Card# \_\_\_\_\_

Expiration Date \_\_\_\_\_

Name on Card \_\_\_\_\_

Billing ZIP \_\_\_\_\_

### Electronic Check

Account Holder's Name \_\_\_\_\_

Account Holder's ZIP \_\_\_\_\_

Account# \_\_\_\_\_

Financial Institution \_\_\_\_\_

Routing & Transit# \_\_\_\_\_

Cardholder's Signature \_\_\_\_\_ Account Holder's Signature \_\_\_\_\_

## C. MONTHLY PAYMENT OPTION

If you select this method of payment for your monthly premium, your payment will automatically be deducted from your checking/savings account each month. Please complete the information below.

I (we) authorize SelectHealth to initiate debit entries to my (our)  **Checking Account**  **Savings Account**

Account Holder's Name \_\_\_\_\_ Account# \_\_\_\_\_

Financial Institution \_\_\_\_\_ Routing & Transit# \_\_\_\_\_

I (we) understand that debit entries will be submitted to my (our) account on or about the tenth of each month, regardless of the policy effective date. I (we) understand that a **\$25.00 service charge** will be assessed if the premium amount cannot be deducted from my (our) account for any reason.

Account Holder's Signature \_\_\_\_\_

## MONTHLY PAYMENT

### 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