

# Application Guide

Please consider the following when choosing between HIPUtah and Federal-HIPUtah:



## HIPUtah Coverage Options

- \$500 Deductible/\$2,000 Out-of-Pocket Maximum
- \$1,000 Deductible/\$3,000 Out-of-Pocket Maximum
- \$2,500 Deductible/\$6,000 Out-of-Pocket Maximum
- \$5,000 Deductible (HDHP)/\$5,000 Out-Of Pocket Maximum

## Rx Benefits

- Separate Rx deductible applies.
- There is no Rx out-of-pocket maximum.

## Prior Coverage

- You may apply for this plan if you are uninsured for any duration.
- Pre-existing conditions may be excluded for the first six months of this plan (maternity is excluded for the first ten months).

## Effective Date

- You may request your desired effective date. SelectHealth reserves the right to make the final effective date determination.



## Federal-HIPUtah Coverage Options

- \$500 Deductible/\$2,000 Out-of-Pocket Maximum
- \$1,000 Deductible/\$3,000 Out-of-Pocket Maximum
- \$2,500 Deductible/\$4,000 Out-of-Pocket Maximum
- \$5,000 Deductible (HDHP)/\$5,000 Out-Of Pocket Maximum

## Rx Benefits

- Separate Rx deductible applies.
- Rx out-of-pocket maximums apply.

## Prior Coverage

- You may apply for this plan if you are uninsured for six months or more.
- Pre-existing condition exclusions do not apply to this plan.

## Effective Date

- Your effective date will be the first day of the month following the month you submit your application.

## BEFORE YOU SUBMIT YOUR APPLICATION FORM, REMEMBER TO...

- Complete entire application**
- Complete Section B**  
Including total annual income for all family members
- Complete Section D**
- Signatures of Applicant and Dates, Sections G and H**
- Include:**
  - Medical records or Physician letter showing diagnosis and prognosis of medical conditions and documentation of lawful admission to the U.S.
  - Health Savings Account Enrollment and Authorization Form, if you choose to establish an HSA with HealthEquity.

**We appreciate your cooperation. Failure to complete this information may delay the review of your application and effective date of coverage.**



## New Enrollee Application Form

Please use dark ink and print legibly. Do not write in shaded areas.

Administered by SelectHealth

### A. COVERAGE AND PAYMENT INFORMATION

Plan Type	Coverage	Payment Option
<i>Select one plan type. Refer to the Application Guide for more information.</i>	<i>Select one deductible</i>	
<input type="checkbox"/> HIPUtah	<input type="checkbox"/> \$500 Deductible	<input type="checkbox"/> Direct Monthly Billing (\$5.00 monthly service fee applies. This option is not available on Federal-HIPUtah plans)
<input type="checkbox"/> Federal-HIPUtah	<input type="checkbox"/> \$1,000 Deductible	<input type="checkbox"/> Preauthorized Banking Withdrawal
Desired Effective Date _____	<input type="checkbox"/> \$2,500 Deductible	<input type="checkbox"/> Online Billing and Payment (See Payment Selection Form)
	<input type="checkbox"/> \$5,000 Deductible	

### B. APPLICANT INFORMATION

**Note: Every person applying for a policy must complete a separate application, including members of the same family.**

#### Applicant

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Social Security# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex  M  F  
Street Address \_\_\_\_\_ Unit# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
E-mail Address \_\_\_\_\_ Home Ph# (\_\_\_\_) \_\_\_\_\_ Work Ph# (\_\_\_\_) \_\_\_\_\_  
Employer \_\_\_\_\_ Employer's Medical Insurance \_\_\_\_\_ Occupation \_\_\_\_\_  
# of People in Household \_\_\_\_\_  
Total Annual Income of All Members of Applicant's Household\* \$ \_\_\_\_\_

*\*Defined as the sum of adjusted gross income from federal tax return for most recent year for all members of applicant's household. Documentation may be requested by HIPUtah to verify household income and is required on application.*

Primary Care Physician Full Name \_\_\_\_\_ Street Address \_\_\_\_\_

#### Responsible Party (to be completed when applicant is a minor younger than age 16 or lacks the legal ability to contract)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Street Address \_\_\_\_\_ Unit# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Social Security# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_  
Employer \_\_\_\_\_ Employer's Medical Insurance \_\_\_\_\_ Occupation \_\_\_\_\_

### C. PRIOR HIPUTAH OR FEDERAL-HIPUTAH COVERAGE

Has applicant ever been covered by the HIPUtah or Federal-HIPUtah program before?  Yes  No  
If yes, date coverage terminated \_\_\_\_\_ Reason for Termination \_\_\_\_\_  
Was the lifetime policy maximum met?  Yes  No  
Has the applicant had coverage similar to HIPUtah or Federal-HIPUtah in another uninsurable risk pool?  Yes  No  
If yes: State \_\_\_\_\_ Plan Ph# (\_\_\_\_) \_\_\_\_\_ Dates of Coverage \_\_\_\_\_ to \_\_\_\_\_  
Was the policy dollar maximum of the above coverage met?  Yes  No  
Reason for Termination \_\_\_\_\_

### SELECTHEALTH USE ONLY

Conditional Eligibility \_\_\_\_\_ State/Federal (circle one) \_\_\_\_\_  
Effective Date \_\_\_\_\_ Points \_\_\_\_\_ HIPAA Eligible \_\_\_\_\_  
Final Status Code \_\_\_\_\_ PEC \_\_\_\_\_

## D. ELIGIBILITY REQUIREMENTS

1. Is the applicant lawfully admitted into or a citizen of the United States?  Yes  No

If "Yes," please provide documentation such as U.S. Passport, U.S. Birth Certificate, Certificate of Citizenship, I-94 Card, Resident Alien Card, Certificate of Naturalization, etc.

2. Is the applicant a resident of Utah?  Yes  No

If "Yes," how long has he or she been a continuous Utah resident? \_\_\_\_\_ years \_\_\_\_\_ months

3. Is the responsible party a resident of Utah?  Yes  No

If "Yes," how long has he or she been a continuous Utah resident? \_\_\_\_\_ years \_\_\_\_\_ months

4. Is the applicant currently covered by or eligible for Medicare?  Yes  No

If "Yes," Medicare number \_\_\_\_\_ Effective Date \_\_\_\_\_

5. Is the applicant currently covered by or eligible for Medicaid?  Yes  No

If "Yes," Medicaid number \_\_\_\_\_ Effective Date \_\_\_\_\_

6. Is the applicant currently covered by or eligible for any other public health plan?  Yes  No

If "Yes," program name \_\_\_\_\_ Effective Date \_\_\_\_\_

7. Is the applicant currently covered by or eligible for any health insurance? (Including employer-sponsored, state extension, COBRA, or group conversion)  Yes  No

If "Yes," health insurance carrier name \_\_\_\_\_ Effective Date \_\_\_\_\_

8. If enrolled, would any employer reimburse or pay for any portion of this plan?  Yes  No

9. Has the applicant either voluntarily cancelled health insurance coverage or been involuntarily cancelled by a health insurance company within the last six months?  Yes  No

If "Yes," please answer the following questions:

- a. Was the coverage under an employer-sponsored program?

Yes  No

- If yes, what date did your prior coverage end? (MM/DD/YYYY)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

- b. Was the coverage under COBRA or state extension?

Yes  No

- c. Was the COBRA or state extension coverage exhausted?

Yes  No

- d. Was the coverage under an individual plan?

Yes  No

- e. Was the coverage under a group conversion plan?

Yes  No

- f. Was the coverage under a government-sponsored plan (e.g. Medicare, Medicaid, etc.)?

Yes  No

- g. Did your employer drop insurance coverage?

Yes  No

- h. Were you self-employed?

Yes  No

- i. Did you lose employment?

Yes  No

- j. Other reasons for loss of coverage \_\_\_\_\_

If you answered yes to any of the above, please complete section "E".

## E. PRIOR/CURRENT COVERAGE INFORMATION

- Will the applicant be losing coverage within the next six months for any reason?  Yes  No

If "Yes," give the dates of current coverage and the reason for termination below.

### PRIOR/CURRENT HEALTH INSURANCE COVERAGE INFORMATION

Please complete the following information about your health insurance coverage for the last 18 months, regardless of whether it is still in effect. If you have had coverage through more than one insurance carrier during that time, please include coverage information for each carrier. Failure to complete information on this form could result in no credit toward the pre-existing condition waiting period.

Please include a letter of Creditable Coverage (termination letter) for those policies listed below with this application.  
The application process will be delayed if it is not included.

The following documentation is also acceptable for submission:

- Explanation of Benefits or other correspondence that indicates coverage
- Health insurance ID card
- Medical record that indicates health coverage
- Pay stubs showing payroll deduction for health coverage
- Certificate of coverage for a group health insurance policy
- Other documentation that shows evidence of health coverage

### LIST BELOW ALL CORRESPONDING INSURANCE POLICIES

	CARRIER 1	CARRIER 2	CARRIER 3
1. TYPE(S) OF COVERAGE			
Employer sponsored			
COBRA			
State extension			
Individual			
Group conversion			
Government sponsored			
2. COVERAGE EFFECTIVE DATE			
3. TERMINATION DATE			
4. INSURANCE CARRIER PH#			
5. REASON FOR COVERAGE TERMINATION (e.g., loss of job, coverage dependent, COBRA expiration, employer dropped coverage, nonpayment of premiums)			

## F. UNINSURABILITY INFORMATION

**1. Has the applicant been denied coverage from any other health insurance carrier?  Yes  No**

If "Yes," please list the type(s) of coverage for which you have applied and the carrier(s): \_\_\_\_\_

Date of Application \_\_\_\_\_ Date of Denial \_\_\_\_\_ (Please attach a copy of denial letter)

**2. Is an application to any other health insurance coverage currently in process for the applicant?  Yes  No**

If "Yes," please list the type(s) of coverage for which you have applied and the carrier(s): \_\_\_\_\_

Date of Application \_\_\_\_\_

**3. Does the applicant, spouse or parent, legal guardian or other responsible party work for an employer that offers health insurance benefits?**

If "Yes," or "Unsure," list the name, address and phone number of each employer. Also list insurance carrier name and reason Applicant is not insured on this program:

Applicant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	_____
Spouse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	_____
Parent, Legal Guardian or other Responsible Party	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	_____

**4. Please list all current medical condition(s) that have prevented the applicant from obtaining other health insurance.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note: All applicants must submit with this application copies of medical records or a physician letter documenting the above medical condition(s). Documentation must specifically show date of onset, diagnosis and prognosis of said medical condition(s). It is the applicant's responsibility to obtain these records at his or her expense. Even if disclosed, non-covered procedures/diagnosis and services provided or ordered to treat complications of a non-covered service, including gastric bypass are not covered.**

## G. AFFIRMATION

I, the applicant (or parent, legal guardian, or responsible party of applicant), affirm that my foregoing answers to questions in Section A through F are complete and correct to the best of my knowledge. I understand that no coverage will be in effect until the full initial premium is paid and this application has been approved and accepted by HIPUtah.

I understand that:

- "Preexisting condition," with respect to a health benefit plan means the following: (a) a condition that was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day; (b) does not include a condition indicated by genetic information unless an actual diagnosis of the condition by a physician has been made.
- Benefits otherwise payable under the policy will be reduced by all amounts paid or payable through any other health coverage, workers-compensation, motor vehicle coverage, or any state or federal law or program.
- If this application contains fraudulent or intentional misstatements or omissions, HIPUtah may do any or all of the following: (a) cancel the agreement as though it were never effective; (b) deny benefits under the "pre-existing condition" exclusion; or (c) take any other action available to it by law.
- I understand that if I am at least 18 years of age and I am not lawfully admitted to the United States, I am not eligible for HIPUtah.

Any matter in dispute between you and HIPUtah or Federal-HIPUtah may be subject to arbitration as an alternative to court action pursuant to the rules of the Utah Uniform Arbitration Act. Any decision reached by arbitration shall be binding upon both you and HIPUtah or Federal-HIPUtah. The arbitration award may include attorney's fees, if allowed by law, and may be entered as a judgment in any court of proper jurisdiction.

### DISCLOSURE AUTHORIZATION

I authorize disclosure of medical record information about me (or about the applicant, if I am other than the Applicant) to HIPUtah or Federal-HIPUtah if needed to (a) determine eligibility for coverage; and/or (b) process claims for benefits.

This authorization takes effect on the date received by the Administrator and remains in effect as follows:

- For information needed to process a claim for benefits, the authorization is effective for the lifetime of the policy or the duration of the timely filing deadline for any claim, whichever is longer.
- For information needed to evaluate the application for coverage, the authorization will be effective for 90 days after the date received by the Administrator.

I understand and agree that by typing in my name I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

**Signature** (Applicant's signature or signature of parent, legal guardian, or responsible party.)

Please type your signature in the box below.

\_\_\_\_\_

Please verify your signature by typing it again.

\_\_\_\_\_

Date Signed.

\_\_\_\_\_

## H. AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This authorization provides for the release of PHI to the Utah Comprehensive Health Insurance Pool (HIPUtah) through its Administrator. Federal privacy laws require health plans to include certain provisions in any authorization for use or disclosure of medical information, other than uses or disclosures for treatment, payment, healthcare operations, and as otherwise required or expressly permitted by law. If HIPUtah or SelectHealth needs to use, disclose, or receive PHI other than for the purposes set forth herein, I understand that I may be required to sign a separate authorization.

On behalf of myself (or the applicant if I am other than the applicant), I authorize any physician, healthcare provider, hospital, insurance, or reinsurance company, or other insurance information exchange to disclose PHI including alcohol, chemical dependency, mental treatment, genetic testing, or HIV treatment to HIPUtah, SelectHealth, or its representatives. I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan, eligibility for benefits, or payment of claims. PHI may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If I choose not to sign this authorization, SelectHealth on behalf of HIPUtah, may be unable to enroll me for coverage under HIPUtah or Federal-HIPUtah, or to pay claims that were incurred while I had insurance coverage with HIPUtah or Federal-HIPUtah.

I understand that I may cancel this authorization at any time by sending a written request to SelectHealth, Inc. at P.O. Box 30192, Salt Lake City, Utah 84130-0192. Cancellation of this authorization will not affect any action HIPUtah or SelectHealth took before it received my request. If I do not revoke this authorization, it will automatically expire upon termination of my coverage with HIPUtah or Federal-HIPUtah, or 24 months from the date at right, whichever comes first.

Federal law requires HIPUtah or SelectHealth to tell me that if the party to whom HIPUtah or SelectHealth, Inc. discloses my PHI shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are subject to federal confidentiality rules (42 CFR part 2). Federal law prohibits redisclosure of such information without specific written authorization.

I understand and agree that by typing in my name I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

### Signature

Please type your signature in the box below.

Please verify your signature by typing it again.

Date Signed.

I understand and agree that by typing in my name I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

### Signature\*

Please type your signature in the box below.

Please verify your signature by typing it again.

Date Signed.

\* If signed by a Personal Representative of the member/enrollee, please complete the following:

Personal Representative's Name \_\_\_\_\_

Relationship to Individual  Parent  Legal Guardian\*\*  Holder of Power of Attorney\*\*

\*\* Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

### THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(PSYCHOTHERAPY NOTES are notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation during a counseling session.)

## I. PRODUCER INFORMATION

Producer Name (Last, First, Initial) \_\_\_\_\_ Social Security# \_\_\_\_\_

Insurance License# \_\_\_\_\_ Ph# (\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_



## Payment Selection Form

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

### A. PAYMENT SELECTION

Please select one of the three 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.

**Preauthorized Banking Withdrawal**

Complete section "B"

**Online Billing and Payment**

Complete section "C." You must include a check for the first month's premium  
You will receive a premium notice by mail once you are accepted

**Monthly Statement**

\$5 Monthly service fee required,  
(Option not available on Federal-HIPUtah plan)

### B. PREAUTHORIZED BANKING WITHDRAWAL

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

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

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

I understand that debit entries will be submitted to my account on or about the 10<sup>th</sup> of each month, regardless of the policy effective date. I understand that a **\$25.00 service charge** will be assessed if the premium amount cannot be deducted from my account for any reason. I understand and agree that by typing in my name I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

#### Account Holder's Signature

Please type your signature in the box below.

Please verify your signature by typing it again.

Date Signed.

### 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                      1839401923

### C. ONLINE BILLING AND PAYMENT

If you have selected the Online Billing and Payment option, complete and sign the agreement below. You will receive your monthly statement by E-mail. This E-mail will link you to a Web site where you can make your monthly payment by electronic check.

Premium payments are due on the first day of each month.

Applicant's Name \_\_\_\_\_ Applicants Date of Birth \_\_\_\_\_

Applicant's E-mail Address \_\_\_\_\_

I understand and agree that by typing in my name I am engaging in an electronic transaction and creating an electronic agreement that is legally binding upon me and those I represent in the same manner as if I had signed a paper document containing the same terms and conditions.

#### Applicant's Signature

Please type your signature in the box below.

Please verify your signature by typing it again.

Date Signed.