

January
08

KidsSM Plan Application Form

A. CHILD INFORMATION (two weeks to 17 years of age)

Last Name _____ First Name _____ Middle Initial _____
 Mailing Address _____ Unit# _____
 City _____ State _____ ZIP _____
 Street Address (if different) _____
 City _____ State _____ ZIP _____
 Sex _____ Date of Birth _____ Age _____ Social Security# (internal use only) _____
 E-mail Address _____ Home Ph#(____) _____ Other Ph# (____) _____

Please check one of the following boxes New Application Re-apply

Payment Option Preauthorized Banking Withdrawal Online Billing and Payment (See Payment Selection Form, p.7)

Please note the following eligibility guidelines when completing the application for a SelectHealth Kids plan:

1. The child must be a full-time resident of Utah.
2. Each child must be enrolled on their own plan with a separate application.
3. The child cannot be married at the time of enrollment.
4. Infants can be covered only after they have had their first routine checkup (usually two weeks).
5. The maximum age for coverage on this plan is 17. At renewal time following the child's 18th birthday, their plan will convert to the SelectHealth individual plan with the most comparable benefits.

B. PARENT/GUARDIAN INFORMATION (required if child is younger than age 16)

Last Name _____ First Name _____ Middle Initial _____
 Mailing Address _____ Unit# _____
 City _____ State _____ ZIP _____
 Street Address (if different) _____
 City _____ State _____ ZIP _____
 E-mail Address _____ Home Ph#(____) _____ Other Ph# (____) _____

C. DUAL COVERAGE/COORDINATION OF BENEFITS INFORMATION

For Dual Coverage/Coordination of Benefit purposes, please indicate if the child will **also be covered** by other medical insurance **while coverage with SelectHealth is in force**. Please do not complete this section if other coverage will be terminated once the SelectHealth plan is in force.

CARRIER NAME	CARRIER PH#	POLICY#	EFFECTIVE DATE (mm/DD/yy)

D. PLAN INFORMATION

SELECT ONE FROM EACH OF THE FOLLOWING: NETWORK, BENEFIT LEVEL, AND DEDUCTIBLE

NETWORK

 

BENEFIT LEVEL AND DEDUCTIBLE

Base-Level Plan

Deductible for all medical services

- \$500 Medical Deductible
 \$1,000 Medical Deductible

High-Level Plan

No deductible for office visits

- \$150 Medical Deductible
 \$500 Medical Deductible
 \$1,000 Medical Deductible

There is no deductible for prescription drugs. The prescription drug benefit is limited to \$500 plan payment per calendar year.

SELECTHEALTH USE ONLY

Class# _____ Plan _____ Effective Date _____
 Agent/Broker _____ Agent/Broker# _____
 Rate Adjustment Percent _____ Monthly Payment \$ _____ PEC Start Date _____ PEC Credit _____

notes

E. HEALTH INFORMATION

INSTRUCTIONS: Answer each question considering the child applying for medical coverage. **Circle any specific item(s)** in the question that applies. Give complete and specific details in Sections F. and G. for each "Yes" (Y) answer.

1. Is the child currently receiving medical treatment? **Y N**
2. Has the child consulted, been tested, or had treatment by a doctor, chiropractor, counselor, therapist, or other healthcare provider within the past **THREE YEARS**? **Y N**
3. Is the child currently pregnant, or do they have reason to suspect they might be pregnant? **Y N**
4. Is the child financially responsible for an unborn child, anticipating adoption, applying for, or have applied for adoption? **Y N**
5. Is the child's parent or guardian covered as a subscriber or dependent on a SelectHealth individual plan? **Y N**
If yes, what is the subscriber number or name on the policy?

6. Has the child ever chewed or smoked tobacco? **Y N**
7. Has the child taken any medication, drugs, shots, or remedies in the past **TWELVE MONTHS**? If yes, complete Section G. **Y N**
8. Within the past **FIVE YEARS** has the child:
 - a) Been advised to be hospitalized, have tests, consultation, evaluation, surgery, or use medication(s), **but has not done so**? **Y N**
 - b) Been evaluated for fertility, is infertile, or had a miscarriage or complication(s) of pregnancy? **Y N**
 - c) Had gallbladder problems, ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, or other digestive problems? **Y N**
 - d) Had urinary problems or urinary incontinence? **Y N**
 - e) Had irregular bleeding, abnormal Pap smears/test, pelvic inflammatory disease, endometriosis, prostate or testicular problems, venereal disease, or any disorder of the reproductive system? **Y N**
 - f) Had migraines, been unconscious, or had epilepsy, seizures, or convulsions? **Y N**
 - g) Received any mental health counseling, psychotherapy, or had a mental or nervous disorder, depression, stress, or anxiety that required consultation or medication? **Y N**
 - h) Had cysts, growths (except for warts), breast lumps, augmentation, or reduction? **Y N**
 - i) Had a skin disorder that required medical attention? **Y N**
 - j) Had a thyroid disorder or a disorder of the lymph nodes or lymph system? **Y N**
 - k) Been treated for chest pain, high blood pressure, or high cholesterol? **Y N**
 - l) Had any disorder of the eyes, ears, nose, or throat that required treatment? **Y N**
 - m) Had any back, neck, or spinal problems, or a joint disorder that required medical attention and/or interfered with normal daily activities? **Y N**
 - n) Had a problem for which they **have not** sought medical advice or treatment? **Y N**
9. Within the past **TEN YEARS**, has the child:
 - a) Been hospitalized or had surgery? **Y N**
 - b) Had hepatitis, colitis, a colectomy or ileostomy, rectal disease, spleen problems, jaundice, or other digestive problems? **Y N**
 - c) Had gout, arthritis, fibromyalgia, lupus, any connective tissue disease or disorder, or any joint replacement? **Y N**
 - d) Been diagnosed with, had treatment or surgery for, or any indication of, but not limited to, ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc(s), spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis? **Y N**
 - e) Had any surgery or treatments for obesity, bulimia, anorexia, weight control, stomach stapling, or gastric bypass? **Y N**
 - f) Had tuberculosis, asthma, sleep apnea, pleurisy, emphysema, or any disorder of the lungs or respiratory system? **Y N**
 - g) Been treated for alcohol use or attended Alcoholics Anonymous® for their own alcohol consumption? **Y N**
 - h) Been treated for drug dependency, abuse, or reaction? . **Y N**
 - i) Been a user of any drug not prescribed, such as: opiates, stimulants, depressants, and/or hallucinogens? . **Y N**
10. Has the child **EVER** had any indication of, diagnosis of, or treatment for:
 - a) Any birth defect, developmental or learning disability, physical, neurological, neuromuscular, or mental impairment(s)? **Y N**
 - b) Bipolar disorder, manic depression, schizophrenia, chronic organic brain syndrome, or any other organic brain or psychotic disorders? **Y N**
 - c) A kidney disorder, liver problems, cirrhosis, or pancreatic problems? **Y N**
 - d) Cancer or tumors? **Y N**
 - e) Diabetes? **Y N**
 - f) Multiple sclerosis, muscular dystrophy, cerebral palsy, or any other neurological disorder? **Y N**
 - g) Any blood disorder, tested positive for Human Immunodeficiency Virus (HIV), or been treated for or been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any disease or disorder of the immune system? **Y N**
 - h) Any heart condition or problem, heart murmur, heart attack, rapid, slow, or irregular heartbeat, blood clot, stroke, or other circulatory problem? **Y N**
11. Has the child been unable to work or been unable to perform routine daily functions for more than two weeks (other than for pregnancy)? **Y N**
12. Does the child have any conditions, symptoms, or problems not otherwise mentioned in connection with answering the above questions? **Y N**
13. To your knowledge, has the child been denied for other health or life insurance or been issued a modified or rated policy? **Y N**
14. List the child's height and weight below. List weight as it is now and as it was **ONE YEAR** ago.
 - a) **Child's Height** _____ ft. _____ in.
Child's Weight _____ now; _____ one year ago

F. ADDITIONAL INFORMATION

QUESTION#	DIAGNOSIS OF ILLNESS INJURY, TREATMENT, TESTING OR MEDICAL TREATMENT	DATE BEGAN (MM/DD/YY)	DATE ENDED (MM/DD/YY)	REMAINING SYMPTOMS OR PROBLEMS	NAME AND PH# OF PHYSICIAN OR HOSPITAL

G. PRESCRIPTION MEDICATION INFORMATION

NAME OF MEDICATION	DOSAGE	DATE BEGAN (MM/DD/YY)	DATE ENDED (MM/DD/YY)	REASON FOR MEDICATION	NAME AND PH# OF PRESCRIBING PROVIDER

H. GENERAL INFORMATION

1. Is any employer reimbursing or paying for any portion of this plan? **Y N**
2. Does the child live, reside, work, or attend school outside the state of Utah at any time during the year? **Y N**

Please explain "yes" answers to the above questions _____

I. PRIOR COVERAGE INFORMATION

Has the child had health insurance coverage within the past 63 days? Yes No If "Yes," list carrier information below.

If you answered "No," when was the last date the child was insured? _____

Has the child EVER been covered under SelectHealth (formerly IHC Health Plans)? Yes No

If "Yes," list Policy# _____ and Policyholder's Name _____

If the child has had continuous healthcare coverage not separated by a break in coverage of 63 days or more, the Pre-Existing Condition Waiting Period limitation may be partially or completely waived. To determine if this applies, **you must enclose proof of prior coverage**. This could include the following: Certificate of Creditable Coverage from the previous carrier, an Explanation of Benefits (EOB) or other correspondence from a plan or issuer indicating coverage, pay stubs showing payroll deduction for health coverage, a health insurance ID Card; a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third-party statements verifying periods of coverage, any other relevant documents that evidence periods of health coverage, or a telephone call from the Plan or provider to the Plan verifying Creditable Coverage. **These documents must include beginning and end dates of coverage.**

You must also provide the following information:

Policyholder's Name _____ Policyholder's Date of Birth _____

Name of Carrier _____ Policy# _____

Effective Date _____ Termination Date _____

Carrier's Address _____ Carrier's Ph# (____) _____

Submission of prior coverage information does not automatically waive the Pre-existing Condition Waiting Period limitation. However, failure to provide prior coverage information will result in an automatic 12-month Pre-existing Condition Waiting Period.

J. AUTHORIZATION AND ACKNOWLEDGMENT

I hereby apply for the child listed on this application to be enrolled for coverage with a SelectHealth Kids plan. When incorporated with the Contract, this application and the Member Payment Summary 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 the child listed on this application. Further, in dealing with SelectHealth, I agree to act on behalf of the child listed on this application. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until the child is approved by SelectHealth, 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 this 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 it is my continuing responsibility to report to the Plan changes in the eligibility of any child who becomes a member.

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 the child's 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 SelectHealth Kids plan coverage for which I am applying may limit or exclude certain conditions and may exclude conditions for which the child 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 limitation 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 for the child to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by SelectHealth. Your new policy provides ten days within which you may decide without cost whether you desire to 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 the child may presently have (pre-existing conditions) may not be immediately or fully covered under the new plan. This could result in a denial or delay of a claim for benefits under the new plan, whereas a similar claim might have been payable under the child's present policy or plan.
2. You may wish to secure the advice of the child's present insurer or its agent regarding the proposed replacement of the present policy. This is not only your right, but it is also in the child's best interest to make sure you understand all the relevant factors involved in replacing the present coverage.
3. If, after due consideration, you still wish to terminate the child's present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning the child's 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 premium as though the child's 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.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the health information on pages 2 and 3, 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.

K. SIGNATURE OF CHILD OR PARENT/GUARDIAN*

Signature

I understand and agree that by typing in my name and/or clicking on the button that says "I agree," 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.

Please type your signature in the box below.

Please verify your signature by typing it again.

Date Signed.

*A representative must have legal authority to sign (e.g., a parent/guardian for a minor child). Generally, a child age 16 or older can sign for themselves, but a parent/guardian can sign for any eligible child.

L. 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 child, or a representative with legal authority;
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; or b) waive any of the terms of 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 will terminate this Agency Agreement.

Date application received at SelectHealth
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Agent/
Broker Name _____ Agency _____ Phone# () _____

Agent Signature

I understand and agree that by typing in my name and/or clicking on the button that says "I agree," 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.

Please type your signature in the box below.

Please verify your signature by typing it again.

Date Signed.

Requested Effective Date ____/____/____

Coverage is not in force until the application is approved and an effective date is determined by SelectHealth.

IF YOU NEED ADDITIONAL SPACE, PLEASE USE ANOTHER APPLICATION FORM.

Authorization to Disclose Health Information to SelectHealth for Pre-Enrollment Underwriting Purposes

NOTICE: By signing this form, you give SelectHealth the right to gather medical information about the child. SelectHealth typically gathers both paper and electronic records. This information helps SelectHealth make an educated decision about insuring the child.

I. AUTHORIZATION

I authorize any health plan and any healthcare provider (including any pharmacy) to disclose medical information about the child to SelectHealth for purposes of determining eligibility for health insurance coverage as requested in the application dated _____. The medical information I authorize to be disclosed includes any medical information related to insurability, except for any genetic test results about me or a blood relative of mine.*

*Utah law prohibits insurers from using genetic test results for underwriting purposes.

II. INFORMATION FOR CHILD OR PARENT/GUARDIAN

I understand the following information:

1. I may refuse to sign this authorization, or I may revoke it if I have not been enrolled in SelectHealth by sending my written request to SelectHealth; however, if I do so SelectHealth may refuse to enroll me;
2. A healthcare provider may not condition the child's treatment on signing this authorization;
3. Another health plan may not condition payment, enrollment, or eligibility for benefits on my signing this authorization;
4. I understand that the information that SelectHealth receives because of this authorization may be redisclosed and no longer protected by federal or state regulation. Items 5 and 6 of this section limit the potential for redisclosure of my information;
5. If SelectHealth does not enroll the child, it may not use or disclose the information it receives because of this authorization for any purpose other than underwriting, except as may be required by law. (If SelectHealth denies insurance coverage because of an individual's health condition, Utah law requires SelectHealth to tell you specifically what this health condition is);
6. If SelectHealth does enroll the child, it will only use information disclosed under this authorization for purposes described in its notice of privacy practices;
7. Unless revoked, this authorization will remain in effect for underwriting purposes until 60 calendar days from the date SelectHealth has approved or rejected this application.

III. IDENTIFYING INFORMATION/SIGNATURES FOR THE CHILD OR PARENT/GUARDIAN (if the child is younger than the age of 16)

I understand and agree that by typing in my name and/or clicking on the button that says "I agree," 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.

Child Name		Date of Birth
Child Signature	Verification of Child or Representative Signature*	Date Signed
Parent/Guardian Name		Date of Birth
Parent/Guardian Signature	Verification of Parent/Guardian or Representative Signature	Date Signed

*A representative must have legal authority to sign (e.g., a parent/guardian for a minor child). Generally, a child age 16 or older can sign for themselves, but a parent/guardian can sign for any eligible child younger than the age of 18.

KidsSM Plan Personal Representative Form

In order to access the child's protected health information, you need to complete this form to establish yourself as the child's personal representative. This requirement is in place to ensure SelectHealth is in compliance with the privacy standards outlined in the federal Health Insurance Portability and Accountability Act (HIPAA). If this form is not completed and submitted to SelectHealth, we will not be able to provide you with information regarding benefits, claims payment, or any other protected health information.

A. CHILD INFORMATION

Last Name _____ First Name _____ Middle Initial _____
Date of Birth _____ Age _____

B. PERSONAL REPRESENTATIVE INFORMATION (Parent/Guardian needing access to child's protected health information)

Last Name _____ First Name _____ Middle Initial _____
Date of Birth _____ Age _____
Street Address _____ Unit# _____
City _____ State _____ ZIP _____
E-mail Address _____ Home Ph#(____) _____ Other Ph# (____) _____

C. DOCUMENTATION OF AUTHORITY

The purpose of this section is to establish your relationship to the child and demonstrate your right to access the child's protected health information. You will be required to supply documentation as outlined below.

PARENT - submit one of the following with this form

- Copy of the child's birth certificate listing you as the mother or father
- Voluntary Declaration of Paternity if the father's name is not listed on the birth certificate
- Court order/divorce decree giving you joint or sole custody of the child
- Court order/divorce decree requiring you to provide the child health insurance
- Verification from another insurance carrier that the child is covered under your policy (e.g., copy of ID Card, Explanation of Benefits.)

GUARDIAN - submit the following with this form

- Court order establishing you as the child's legal guardian

D. DOCUMENTATION OF IDENTITY

The purpose of this section is to verify your identity. You will need to supply a copy of one of the following government-issued forms of photo identification:

- Driver's License
- Passport
- Military Identification
- Other (describe) _____

If documentation other than that described on this form is used to verify a personal representative's authority or identity, use of such documentation must be approved by the Intermountain Healthcare privacy administrator.

E. PASSWORD INFORMATION

Provide a password and security question/answer below. When you call SelectHealth to request protected health information, you will be asked to supply this password before the information can be given. If you are not able to supply the password, you will be asked to answer the security question.

Password _____

Security Question _____

Security Question Answer _____

F. PERSONAL REPRESENTATIVE SIGNATURE

By signing below, you declare the information provided on this SelectHealth Kids Plan Personal Representative Form is correct and accurate and that you do have a right as the parent or legal guardian of the child to access the child's protected health information in accordance with HIPAA.

I understand and agree that by typing in my name and/or clicking on the button that says "I agree," 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

Please type your signature in the box below.

Please verify your signature by typing it again.

Date Signed.

KidsSM Plan Payment Selection Form

Child's Name _____ Child's Social Security# OR Subscriber ID# _____
(internal use only)

A. PAYMENT SELECTION

Please select one of the two available methods of payment for the monthly premium. **An employer cannot** pay any portion of the 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.)

B. PREAUTHORIZED BANKING WITHDRAWAL

If you select this method of payment for the monthly premium, 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 **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 tenth 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.

Account Holder's Signature

I understand and agree that by typing in my name and/or clicking on the button that says "I agree," 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.

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	183940 1923

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 or by credit card.

This method of payment requires that you submit the first month's premium using a check or credit card with your application. Premium payments are due on the first day of each month.

Credit/Debit Card (for first month's premium only)

Select Card Type

Visa MasterCard® Discover® American Express®

Card# _____ Expiration Date _____

Name on Card _____ Billing ZIP _____

I understand and agree that by typing in my name and/or clicking on the button that says "I agree," 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.

Card Holder's Signature

Please type your signature in the box below.

Please verify your signature by typing it again.

Date Signed.

Child or Parent/Guardian Signature

Please type your signature in the box below.

Please verify your signature by typing it again.

Date Signed.

E-mail Address _____

Child's Date of Birth _____

Applicant's Ph# _____

Application Checkoff List

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

- Complete Sections A to K**
 - Read Section J** — Authorization and Acknowledgement
 - Sign Section K** — Signature of Child or Parent/Guardian
 - Sign the Personal Representative Form**
 - Sign the Payment Selection Form**
 - Include the first month's premium**
(applies to the Online Billing and Payment option)
- Attach a voided check for Preauthorized Banking Withdrawal**