Enrollment Form (See reverse side for instructions)

I am (Please check one):

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

Please make selection(s) below (Form is not complete unless a box is checked)

☐ **Select Med Plus HealthSave℠**

☐ **Select Med Plus℠**

☐ **Select Value℠**

A. EMPLOYEE INFORMATION (Please print legibly)

LEGAL NAME (Last) (First) (Middle Initial)

DATE OF BIRTH (MM/DD/YYYY) SOCIAL SECURITY NUMBER

MAILING ADDRESS

CITY STATE ZIP

STREET ADDRESS (if different)

CITY STATE ZIP

HOME PHONE CELL PHONE E-MAIL ADDRESS

SEX
☐ Male ☐ Female

Please select your preferrred language / Seleccione el idioma de su preferencia / Aah shoodi, heedigi sha'a saad ninii ziin?
☐ English ☐ Spanish ☐ Navajo ☐ Other

MARITAL STATUS
☐ Single ☐ Legally Married

If you are enrolling due to a special event, check all that apply:
☐ Birth/adoption ☐ Marriage ☐ Loss of other coverage

EMPLOYEE'S PRIOR COVERAGE You must give proof of prior coverage to SelectHealth/SelectHealth BAC as soon as reasonably possible.

CARRIER _____ DATE COVERAGE ENDED ____/____/____

B. 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 and dependents age 18 or older must complete the HSA Enrollment and Authorization to Disclose Health Information to HealthEquity Form.

GROUP NAME _____ GROUP # _____

SUBGROUP NAME _____ SUBGROUP # _____

CLASS NAME _____ CLASS ID # _____

HIRE DATE (MM/DD/YYYY) ____/____/____ EMPLOYEE'S MEDICAL PLAN EFFECTIVE DATE (MM/DD/YYYY) ____/____/____

EMPLOYEE'S PAYROLL STATUS _____

Comments _____

Employer Signature _____ Date ____/____/____

C. WAIVER OF COVERAGE

I have been given the opportunity to enroll and choose to waive such coverage. I have read the information in "Section C" on the first page 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).   ☐ I do not want to buy health insurance at this time.

☐ I already have dental insurance through ______________________ (INSURANCE COMPANY NAME).   ☐ I do not want to buy dental insurance at this time.

Employee Signature ______________________ Date ____/____/____

D. DEPENDENT INFORMATION

Complete this section in full. List yourself and all eligible dependents (spouse and children) whom you wish to be covered and elect the coverage desired. 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).

NUMBER OF DEPENDENTS YOU ARE ENROLLING ______________________

COVERAGE

☐ MEDICAL   **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

DATE OF BIRTH (MM/DD/YYYY)   SOCIAL SECURITY NUMBER

SEX: ☐ M ☐ F   RELATIONSHIP: ☐ Spouse ☐ Dependent

☐ MEDICAL   **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

DATE OF BIRTH (MM/DD/YYYY)   SOCIAL SECURITY NUMBER

SEX: ☐ M ☐ F   RELATIONSHIP: ☐ Dependent

☐ MEDICAL   **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

DATE OF BIRTH (MM/DD/YYYY)   SOCIAL SECURITY NUMBER

SEX: ☐ M ☐ F   RELATIONSHIP: ☐ Dependent

☐ MEDICAL   **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

DATE OF BIRTH (MM/DD/YYYY)   SOCIAL SECURITY NUMBER

SEX: ☐ M ☐ F   RELATIONSHIP: ☐ Dependent

☐ MEDICAL   **LEGAL NAME OF MEMBER TO BE COVERED** (Last) (First) (Middle Initial)

DATE OF BIRTH (MM/DD/YYYY)   SOCIAL SECURITY NUMBER

SEX: ☐ M ☐ F   RELATIONSHIP: ☐ Dependent

Are you and/or your ex-spouse required by a divorce decree to pay the medical expenses of your dependent(s)? ☐ Yes ☐ No

If yes, you must attach a copy of the divorce decree to this Enrollment Form. Include the first page of the decree, the signature page, and any other portion(s) of the decree that specifies responsibility for dependent coverage.

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.

Will you or any of your dependent(s) have other health or dental insurance in addition to this plan? ☐ Yes ☐ No   If yes, complete COB Form.

E. EMPLOYEE AGREEMENT AND SIGNATURE

This section requires that you turn to the first page of this form and read the information in "Section E. Employee Agreement and Signature."
I hereby certify that I have read, understand, and agree to the terms outlined in "Section E. Employee Agreement and Signature" on the first page of this Enrollment Form. After your employer has approved this form, please keep a copy for your records.

Employee Signature ______________________ Date ____/____/____