IHC HEALTH PLANS℠
IHC® A Service of Intermountain Health Care

SE EMPLOYEE APPLICATION

IHC Small Employer Group Products
IHC Health Plans, Inc.
P.O. Box 30192
Salt Lake City, UT 84130-0192

For instructions regarding this application, please refer to section X. "Enrollment Instructions".

I. EMPLOYEE INFORMATION

(Please print using ink)

LAST NAME: FIRST: INITIAL: SOCIAL SECURITY #: – –

ADDRESS: UNIT #: MARITAL STATUS: ❑ Single ❑ Married ❑ Separated ❑ Divorced

CITY: STATE: ZIP: HOME PH #: ( ) WORK PH #: ( )

COMPANY NAME: *FULL-TIME HIRE DATE: / / # OF HRS. WORKED WEEKLY:

JOB TITLE: PERSONAL E-MAIL ADDRESS:

* Full-Time Hire Date is the first day physically at work, working 30 hours or more per week consistently. Providing an incorrect hire date could result in coverage being delayed or denied.

CHECK THE APPROPRIATE BOX ❑ New Group ❑ New Hire ❑ Open Enrollment ❑ Dependent Addition ❑ *Special Enrollment Event

Are you adding a dependent because of a court or administrative order? ❑ No ❑ Yes (If yes, please attach a copy of the notice to this form)

*If you and/or your dependent(s) are enrolling as a result of a Special Enrollment Event, check all that apply:

❑ Birth/Adoption ❑ Marriage ❑ Involuntary Loss of Other Coverage

An SE Employee Application for a special enrollment event must be submitted within 31 days of the event in addition to the applicable documentation, which includes a copy of adoption and/or placement papers, marriage certificate. A Certificate of Creditable Coverage (to prove involuntary loss of other coverage) must be submitted within 60 days.

II. PLAN INFORMATION

Choose **one** of the following plans: ❑ IHC Med℠ ❑ SelectMed℠ ❑ SelectMed PLUS℠ ❑ IHC Care℠ ❑ IHC Care PLUS℠

III. EMPLOYEE AND DEPENDENT INFORMATION

LIST YOURSELF AND ELIGIBLE DEPENDENT(S) TO BE COVERED BELOW:

RELATIONSHIP	NAME (FIRST, MIDDLE INITIAL, LAST)	SOCIAL SECURITY #	SEX	BIRTH DATE (MM/DD/YY)	AGE	OTHER INS.[3]	NAME OF CARRIER[3]
EMPLOYEE		- -	M/F	/ /		Y/N	
SPOUSE[1]		- -	M/F	/ /		Y/N	
CHILD[2]		- -	M/F	/ /		Y/N	
CHILD[2]		- -	M/F	/ /		Y/N	
CHILD[2]		- -	M/F	/ /		Y/N	
CHILD[2]		- -	M/F	/ /		Y/N	
CHILD[2]		- -	M/F	/ /		Y/N	

1. If you are adding your spouse, he or she may only be deleted from your coverage under the following circumstances:
- During your employer's annual open enrollment period;
- When your spouse agrees to be deleted from coverage by signing a Change Form; or
- When proof of a legal divorce or annulment is given (first and last page of the divorce decree and any page in between specifying coverage responsibilities for dependent children if you have elected family coverage).

2. To be eligible for coverage, children must be under the age of 26, unmarried, and dependent upon you for 50 percent of their financial support. (Financial dependency is not required for court or administrative ordered dependent coverage.) Any dependent **not** listed will **not** be considered for coverage.

3. For coordination of benefit purposes, indicate whether or not each individual will be covered by other medical insurance while this IHC health plan is in force. If you answered yes (Y), indicate the name of the other insurance carrier.

IV. PRIOR COVERAGE INFORMATION

If you have had health insurance coverage within the last 63 days, your Pre-existing Condition Waiting Period limitation may be credited or waived upon receipt of your Certificate of Creditable Coverage from your prior health care plan. To determine if this applies to you, **enclose a copy of the Certificate of Creditable Coverage for each member to be covered** and provide the following information. (Note: A photocopy of your ID Card from your current/previous carrier is not acceptable.)

POLICYHOLDER'S NAME: NAME OF CARRIER:

POLICY #: DATE COVERAGE BEGAN: DATE COVERAGE ENDED:

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 limited or excluded benefits for a 12-month period (18 months for late enrollees).

V. EMPLOYEE SIGNATURE

EMPLOYEE SIGNATURE: ______________________ DATE SIGNED: ______________________

IHC HEALTH PLANS' USE ONLY

EFFECTIVE DATE: RENEWAL DATE: NHWP: ❑ 30 ❑ 60 ❑ 90 ❑ OTHER____________

GROUP #: SUB GROUP #: CLASS #: PLAN CODE/PLAN:

PEC WAITING PERIOD/START DATE:

PEC CREDIT:

AGENT/BROKER: GA:

VI. HEALTH INFORMATION

INSTRUCTIONS: Answer each question for each individual applying for medical coverage. **Circle any specific item(s)** in the question that applies. Give complete and specific details in Sections VII and VIII for each yes (Y) answer.

1. Is anyone currently receiving medical treatment? .... Y N
2. Has anyone consulted, been tested, or had treatment by a doctor, chiropractor, counselor, therapist, or other health care provider within the past **three years**? ...... Y N
3. Is any family member currently pregnant, or do they have reason to suspect they might be pregnant? .... Y N
4. Are you or your spouse financially responsible for an unborn child, anticipating adoption, applying for, or have applied for adoption? .... Y N
5. Do you have any family members who are not applying for coverage? If yes, complete **(a)** below. .... Y N
   - **a)** List the reason(s) why any family members are not applying for coverage, and describe their health status.

   ____

   ____

   ____

   ____

   ____

   ____

   ____

   ____

   ____

   ____

6. Has anyone ever chewed or smoked tobacco? .... Y N
7. Has anyone taken any medication, drugs, shots, or remedies in the past **twelve months**? If yes, complete Section VIII. .... Y N

8. **Within the past FIVE YEARS has any proposed member:**
   - **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/tests, 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, 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? .... Y N
   - **m)** Had any back, neck, spinal problems, or a joint disorder that required medical attention and/or interfered with normal daily activities? .... Y N
   - **n)** Does anyone have a problem for which they have not sought medical advice or treatment? .... Y N

9. **Within the past TEN YEARS, has any proposed member:**
   - **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 any proposed member 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 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 problems? ...... Y N

11. Has anyone 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 anyone have any conditions, symptoms, or problems not otherwise mentioned in connection with answering the above questions? .... Y N
13. To your knowledge, has anyone been denied for other health or life insurance or been issued a modified or rated policy? .... Y N
14. List the applicant's and the applicant's spouse's height and weight below. List weight as it is now and as it was **one year ago.**
    - **a)** **Applicant's Height:** __________ ft. __________ in.
      Applicant's Weight: __________ now; __________ one year ago
    - **b)** **Spouse's Height:** __________ ft. __________ in.
      Spouse's Weight: __________ now; __________ one year ago

VII. ADDITIONAL INFORMATION – Complete for Every Yes (Y) Answer in Section VI

QUESTION #	FIRST NAME OF INDIVIDUAL	DIAGNOSIS OF ILLNESS, INJURY, TREATMENT, TESTING, OR MEDICAL ATTENTION	DATE BEGAN (MM/DD/YY)	DATE ENDED (MM/DD/YY)	REMAINING SYMPTOMS OR PROBLEMS	NAME AND PHONE # OF DOCTOR OR HOSPITAL

VIII. PRESCRIPTION MEDICATION INFORMATION

FIRST NAME OF INDIVIDUAL	NAME OF MEDICATION	DOSAGE	DATE BEGAN (MM/DD/YY)	DATE ENDED (MM/DD/YY)	REASON FOR MEDICATION	NAME AND PHONE # OF PRESCRIBING DOCTOR

IX. AUTHORIZATION AND ACKNOWLEDGMENT

I hereby apply to be enrolled with my listed dependent(s), if applicable, for coverage with IHC Health Plans, Inc. 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 dependent(s). Further, in dealing with IHC Health Plans, Inc., I appoint my employer to act as agent on behalf of myself and my dependent(s). I understand that coverage is dependent upon the satisfaction of applicable underwriting criteria and is subject to the terms and conditions of my employer's Master Group Contract with IHC Health Plans, Inc. I also understand no coverage will be in force until each person listed is approved by IHC Health Plans, Inc., that no benefits will be provided for any service which begins before coverage is effective, and that except as expressly provided in the Master Group Contract, benefits will not extend beyond the termination of either my coverage or the Master Group Contract. I represent that all information provided on this application, including the “Health Information” section, is true and complete. I understand that omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or void any coverage issued.

CONSENT AT ENROLLMENT. I understand that my choice of health care providers whose services will be covered may be restricted by the Master Group Contract, and I agree that any services which are obtained without or contrary to required preauthorization/precertification requirements in the Master Group Contract may be denied. I understand the coverage which I am applying for 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 limitation provision of the Master Group Contract. If the Master Group Contract provides that contributions be made, I authorize my employer to deduct them from my pay.

I hereby declare that to the best of my knowledge and belief, the information given on this Application, including the health information is correctly recorded, true, and complete. If I subsequently become aware of information different from that provided on this Application, I agree to provide that additional information promptly to IHC Health Plans, Inc.

X. ENROLLMENT INSTRUCTIONS

You must read Section IX. “Authorization and Acknowledgment” before signing this Application. It contains policy and terms for agreement. Faxed applications will not be accepted; only original applications will be processed.

All areas of the Application should be completed in detail by you. It is your responsibility to read and understand this information and follow the instructions given. Please print clearly in ink. Illegible or incomplete Applications will delay processing.

The following instructions will help you complete this Application. If you need further help, contact your employer, agent/broker, or an IHC Health Plans' representative at **1-801-442-4908 Option 2** or **1-800-442-3125 Option 2**.

Sections I and II - EMPLOYEE INFORMATION AND PLAN INFORMATION

Please note: Section I - The definition of Full-Time Hire Date is as follows: First day physically at work, working 30 hours or more per week consistently. Providing an incorrect hire date could result in coverage being delayed or denied.

Section III - EMPLOYEE AND DEPENDENT INFORMATION

Complete this section with all requested information about you and/or your dependent(s). If your spouse is enrolled, he or she may only be deleted for the reasons stated in Section III,1.

NOTES: You must list other health insurance information for each member applying for coverage in order for IHC Health Plans to coordinate benefits with other carriers when necessary. On the same line as the member to be covered, circle Y (Yes) or N (No) to indicate whether they will have other insurance coverage along with IHC's plan. You must also list the name of the carrier.

Section IV - PRIOR COVERAGE INFORMATION

If you and/or your eligible dependent(s) have had health insurance coverage within the last 63 days, your Pre-existing Condition Waiting Period (if applicable) may be credited or waived. You must provide IHC Health Plans proof of prior coverage, such as Certificate of Creditable Coverage, for each member. You have the right to request a Certificate of Creditable Coverage from your prior health care plan. If necessary, IHC Health Plans, Inc. will assist in obtaining such Certificates.

Section V - EMPLOYEE SIGNATURE

You must read Section IX. “Authorization and Acknowledgment”. If you read, understand, and agree to the terms stated, sign and date this section.

Section VI - HEALTH INFORMATION

Answer each question for each individual applying for medical coverage. Circle any specific item(s) in the question that applies. For each yes (Y) answer, **give complete and specific details** in Section VII and VIII.

Section IX - AUTHORIZATION AND ACKNOWLEDGMENT

You must read this section. If you read, understand, and agree to the terms stated, sign and date Section V. “Employee Signature”.

© 2003, 2004 IHC Health Plans, Inc. All rights reserved. 06/04