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

PO Box 30192
Salt Lake City, UT 84130-0192
Tel: 1-801-442-3599 or 1-800-660-3599

IHC Personal Managed Care Plans
Application Form

Please use ink and print legibly

I. APPLICANT INFORMATION (Must be oldest family member)

Last Name	First Name	Initial
Address	Unit #	Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced
City	State	ZIP
Your Occupation	Your Spouse's Occupation	
E-Mail Address	Home Ph #	Work Ph #

Please check one of the following boxes: ❑ New Application ❑ Dependent Addition ❑ Re-apply

II. APPLICANT AND DEPENDENT INFORMATION

LIST YOURSELF AND ELIGIBLE FAMILY MEMBERS TO BE INCLUDED UNDER MEDICAL COVERAGE BELOW:

Relationship	Name (First, Middle Initial, Last)	Social Security # (For Internal Use Only)	Sex	Birth Date (MM/DD/YY)	Age
Self					
Spouse[1]					
Child[2]					
Child[2]					
Child[2]					
Child[2]					
Child[2]					
Child[2]					
Child[2]					

1. If you are **adding your spouse**, he or she may only be deleted from your coverage under the following circumstances:
- When your spouse agrees to be deleted from coverage by signing a Personal Plan's 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 ordered dependent coverage.) Any dependent not listed will not be considered for coverage.

III. DUAL COVERAGE/COORDINATION OF BENEFITS INFORMATION

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

Relationship	Name of Individuals Covered by other insurance	Carrier Name	Carrier Ph #	Policy Number	Effective Date

IHC HEALTH PLANS' USE ONLY

Class #	**Plan**	**Agent/Broker**	**Agent/Broker #**
Effective Date		**Rate Adjustment Percent**	**Monthly Payment $**
PEC Start Date		**PEC Credit**	
HPI Notes			

If you need additional space, please use another application form.

IV. PLAN INFORMATION

SELECT ONE FROM EACH OF THE FOLLOWING (Network, Plan Option, and associated benefit selections):

NETWORK ❑ IHC Med℠ ❑ SelectMed℠ ❑ IHC Care℠ — **Select one network**

PERSONAL IHC MED℠
A Product of IHC Health Plans

PERSONAL SELECTMED℠
A Product of IHC Health Plans

PERSONAL IHC CARE℠
A Product of IHC Health Plans

PLAN OPTIONS ❑ HMO Plans ❑ HealthSave Plans — **Select one plan option and complete associated Benefit Selection below**

HMO option – Benefit Selection

BENEFIT AND DEDUCTIBLE ***Select benefit level (Base, Mid, or High) and deductible***

❑ **Base-Level Plan**
Deductible applies to all services first
- ❑ $250 Medical Ded ($100 Rx Ded)
- ❑ $500 Medical Ded ($200 Rx Ded)
- ❑ $1,000 Medical Ded ($400 Rx Ded)
- ❑ $2,500 Medical Ded ($1,000 Rx Ded)

❑ **Mid-Level Plan**
No deductible for office visits, with deductible for Rx
- ❑ $250 Medical Ded ($100 Rx Ded)
- ❑ $500 Medical Ded ($200 Rx Ded)

❑ **High-Level Plan**
No deductible for office visits, no deductible for Rx
- ❑ $250 Medical Ded
- ❑ $500 Medical Ded
- ❑ $1,000 Medical Ded

COINSURANCE/COPAYMENT ***Select one coinsurance and copayment amount***

❑ 70/30–$25/35 ❑ 80/20–$15/25

HealthSave option – Benefit Selection

DEDUCTIBLE ***Select one deductible either under Single or Family***
Deductible applies to all services except preventive care

❑ **Single**
- ❑ $1,500 Deductible (You pay 20% coinsurance after deductible)
- ❑ $5,000 Deductible (Covered 100% after deductible)

❑ **Family**
- ❑ $3,000 Deductible (You pay 20% coinsurance after deductible)
- ❑ $10,000 Deductible (Covered 100% after deductible)

❑ **Are you electing to use IHC Health Plans' preferred HSA vendor? (Selected HSA Vendor)**
- ❑ Yes
- ❑ No

Note: You may choose to use this option with a Health Savings Account (HSA). IHC Health Plans has made a concerted effort to design the coverage in compliance with the requirements for a High Deducible Health Plan (HDHP) under federal law (Section 223 of the Internal Revenue Code).

However, IHC Health Plans makes no representations or warranties about the legal adequacy of this coverage as an HSA compatible plan. IHC Health Plans is not responsible for any issues relating to your use of the coverage in conjunction with an HSA including, without limitation, your compliance with the requirements of the Internal Revenue Code.

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

Authorization to Disclose Health Information to IHC Health Plans for Pre-Enrollment Underwriting Purposes

Notice: By signing this form, you give IHC Health Plans the right to gather medical information about you and your dependents for whom you have legal authority to sign (e.g. a minor child). IHC Health Plans typically gathers both paper and electronic records. This information helps IHC Health Plans make an educated decision about insuring you and your dependents.

I. Identifying Information for the Applicant and Dependents

Applicant			Date of Birth
Spouse			Date of Birth
Child			Date of Birth
Child			Date of Birth
Child			Date of Birth
Child			Date of Birth
Child			Date of Birth
Current Address	City	State	Zip
Phone Number			

II. Authorization

I authorize any health plan and any healthcare provider (including any pharmacy) to disclose medical information about me to IHC Health Plans for purposes of determining my eligibility for health insurance coverage as requested in the application dated _____ ("My Application"). The medical information I authorize to be disclosed includes any medical information related to my 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.

III. Information for Applicant and Dependents

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 IHC Health Plans; however, if I do so IHC Health Plans may refuse to enroll me;
2. A health care provider may not condition my treatment on my signing this Authorization;
3. Another health plan may not condition payment, enrollment, or eligibility for benefits on my signing this Authorization;
4. If IHC Health Plans does not enroll me, 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 IHC Health Plans denies insurance coverage because of an individual's health condition, Utah law requires IHC Health Plans to tell the applicant specifically what this health condition is);
5. If IHC Health Plans does enroll me, it will only use information disclosed to it under this Authorization for purposes described in its notice of privacy practices;
6. Unless revoked, this Authorization will remain in effect until the earlier of:
   a. The date that IHC Health Plans has rejected My Application for insurance; or
   b. 60 calendar days from the date of My Application.

IV. Signatures

Applicant	If signed by representative, legal authority#	Date
Spouse	If signed by representative, legal authority#	Date
Child	If signed by representative, legal authority#	Date
Child	If signed by representative, legal authority#	Date
Child	If signed by representative, legal authority#	Date
Child	If signed by representative, legal authority#	Date
Child	If signed by representative, legal authority#	Date

#A representative must have legal authority to sign (e.g. a parent/guardian for a minor child). Generally, a spouse and children over 18 years of age must sign for themselves.

V. HEALTH INFORMATION

INSTRUCTIONS: Answer each question considering each individual applying for medical coverage. **Circle any specific item(s)** in the question that applies. Give complete and specific details in Sections VI and VII 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 and where they are currently covered.

_____

_____

_____

_____

_____

_____

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 VI. . . . . (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) Had 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 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 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

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

VI. ADDITIONAL INFORMATION

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 PHYSICIAN OR HOSPITAL

VII. 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 PHYSICIAN

VIII. GENERAL INFORMATION

1. Is any employer reimbursing or paying for any portion of this plan? . . . . . (Y) (N)

2. Are you self-employed? . . . . . (Y) (N)

2a. If self-employed, do you have any full or part-time employees? . . . . . (Y) (N)

3. Does any listed proposed member 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: _____

IX. PRIOR COVERAGE INFORMATION

Do you currently have health insurance coverage? . . . . . ❑ Yes ❑ No If "Yes," list carrier information below.

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

Have you EVER been covered under IHC Health Plans . . . . . ❑ Yes ❑ No

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

If you have had continuous health care coverage within the last 63 days, your Pre-Existing Condition Waiting Period limitation may be partially or completely waived. To determine if this applies to you, **you must enclose proof of prior coverage**. This could include the following: Certificate of Creditable Coverage from your 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. **You must also provide the following information:**

Policyholder's Name _____ Name of Carrier _____

Policy Number _____ Effective Date _____ Termination Date _____

Carrier's Address _____ Carrier's Phone Number _____

If you were previously insured on a group plan, have you exhausted your COBRA rights? . . . . . ❑ Yes ❑ No ❑ Not Available

(COBRA rights are your rights to continue coverage for 18 to 36 months after terminating employment.)

If "Yes," please list dates: Date Started _____ Date Ended _____

If COBRA was not an option for you, have you exhausted your Utah mini-COBRA rights? . . . . . ❑ Yes ❑ No ❑ Not Available

(Utah mini-COBRA rights are your rights to continue group health coverage.)

If "Yes," please list dates: Date Started _____ Date Ended _____

Have you ever been or are you currently insured through the Utah Comprehensive Health Insurance Pool (HIPUtah)? ❑ Yes ❑ No

If "Yes," please list dates: Date Started _____ Date 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 an automatic 12-month Pre-existing Condition Waiting Period.

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

X. AUTHORIZATION AND ACKNOWLEDGMENT

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with IHC Health Plans, Inc. 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 my spouse and other dependents. Further, in dealing with IHC Health Plans, 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 IHC Health Plans, 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 questions inaccurately, untruthful, 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 applicants who become members.

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 health care 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 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 you have furnished, you may intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by IHC Health Plans, Inc. 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 which may affect the insurance protection available to you under the new plan.

1. Health conditions which you 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 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.

I hereby declare that to the best of my knowledge and belief, the information given on this Application, including the health information on pages two and three of this Application, 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 IHC Health Plans.

XI. SIGNATURE OF APPLICANT AND SPOUSE

Signature Applicant Sign and Date Here Date Signed

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

XII. 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 IHC Health Plans, Inc., or **b)** waive any of the terms of conditions of the contract.
4. I have no authority to assign effective dates or to effect membership changes.
5. Cancellation of this Health Care Agreement by either the subscriber or IHC Health Plans, Inc. will terminate this Agency Agreement.

Date application received at IHC Health Plans, Inc.

Agent/
Broker Name Agency PH#

Agent/Broker Sign and Date Here

Agent Signature Date Signed

Requested Effective Date_____
Coverage is not in force until your application is approved and an effective date is determined by IHC Health Plans, Inc.

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

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IHC Personal Managed Care Plans
Payment Selection Form

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.

- ❑ **Pre-Authorized Banking Withdrawal** *(Complete Section B)*
- ❑ **Electronic Billing and Payment** *(Complete Section C. You must include a check for the first month's premium)*

B. PRE-AUTHORIZED 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 (we) authorize IHC Health Plans, Inc. to initiate debit entries to my (our): ❑ **Checking Account** ❑ **Savings Account**

Account Holder's Name | **Account Number**

Financial Institution | **Routing and Transit Number**

I (we) understand that debit entries will be submitted to my (our) account on or about the 10th 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 | **Date**

Applicant's Name | **Applicant's Social Security # (for internal use only)**

Pre-Authorized 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.

C. ELECTRONIC BILLING AND PAYMENT

If you have selected the Electronic 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 an Internet 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 with your application. Premium payments are due on the first day of each month.

Applicant's Name | **Applicant's Signature**

Applicant's E-mail Address | **Applicant's Date of Birth**

Application Checkoff List

Before you submit your application, did you remember to…

- ☐ Complete Sections I to XI
- ☐ Read Section X – Authorization and Acknowledgment
- ☐ Sign Section XI – Signature of Applicant and Spouse
- ☐ Sign the Payment Selection Form
- ☐ If you have chosen the Electronic Billing and Payment option, you must include the first month's premium with the Application.
- ☐ Attach a voided check for Pre-Authorized Banking Withdrawal