



## Utah Enrollment Form and Instructions Large Employer

You must read all instructions before completing and signing the Enrollment Form because it contains terms for agreement. If you need help, contact a Human Resources/Personnel representative at your place of employment or call Member Services at **801-442-5038** (Salt Lake area) or **800-538-5038**.

### SECTION A. EMPLOYEE INFORMATION

Complete this section with all of the requested information about yourself (the employee applying for coverage).

### SECTION B. EMPLOYER USE ONLY

An authorized representative of the employer group must complete this section.

- Group Name, Subgroup Name, and Class Name – This information can be provided by your agent or sales representative.
- Employee's Payroll Status – Indicates the current employment classification of the subscriber. For example, please indicate if he or she is an active employee, on an approved leave of absence, or retired.
- Comments – This section may be used to communicate any other pertinent information to Select Health/Select Health Benefit Assurance Company.
- Employer's Signature – An authorized representative of the employer must sign and date this section to validate the form.

### SECTION C. WAIVER OF COVERAGE

Complete and sign this section if you wish to waive healthcare coverage at this time.

You and your dependents may not be eligible to enroll again until the next open enrollment period established by your employer and Select Health/Select Health BAC, unless you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance coverage. You may, in the future, be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption (special enrollment event), you may be able to enroll yourself, your spouse, and the new dependent(s) if you request enrollment within 31 days of the special enrollment event.

### SECTION D. DEPENDENT INFORMATION

Complete this section with all of the requested information about you and your dependent(s).

- If your dependent child is older than the age limit specified in the agreement with Select Health/Select Health BAC and your employer, but still eligible for coverage because of a physical or mental disability, you must attach proof of the dependent's disability to this form.
- If you or your eligible dependents have other health or dental (if applicable) insurance, you must complete the Secondary Medical Coverage Form (COB) to facilitate accurate coordination of benefits with other carriers.

If your spouse is added, he or she may only be deleted from your coverage in the following circumstances:

- During your employer's next open enrollment period;
- When proof of a legal divorce or annulment is given to Select Health/Select Health BAC; or
- When your spouse agrees by signing the Employee Change Form (if allowed by your employer's eligibility rules).

### SECTION E. EMPLOYEE AGREEMENT AND SIGNATURE

You must read and understand the following information. After you have read and agreed to the following terms of this form, sign under "Section E. Employee Agreement and Signature." Otherwise, this application and enrollment may not be valid.

- I hereby apply for membership in Select Health/Select Health BAC for the persons listed on this application (herein referred to as applicants) and agree to submit premiums as required by Select Health/Select Health BAC or authorize my employer to deduct from my earnings the necessary contributions, if any, required of me. I accept the terms of the group agreement between my employer and Select Health/Select Health BAC and appoint my employer to act as an agent on my behalf. I understand that said agreement is on file with the employer and Select Health/Select Health BAC and is available for my inspection. I understand that any intentional material misrepresentation in answering the questions on this application or nonpayment of premiums may result in rescission or cancellation of my coverage and that of my dependents.

# Enrollment Form (See reverse side for instructions)

I am (Please check one):

- A new enrollee       Switching from another Select Health plan (list plan)       Switching from another carrier (list carrier)

G1020433

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

- Select Health Med       \$2500/\$5000 HDHP  
 Select Health Value

HealthEquity

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      MARITAL STATUS  Single  Legally Married

Preferred Language\*\*  English  Spanish  Chinese  Vietnamese  Korean  Navajo  Nepali  Tongan  Serbo-Croatian  Tagalog  
 German  Russian  Arabic  French  Japanese  Mon-Khmer, Cambodian  Other \_\_\_\_\_

Race  White  Black or African American  American Indian or Alaska Native  Asian  Native Hawaiian or Other Pacific Islander  Other

Ethnicity  Hispanic or Latino  Not Hispanic or Latino

Citizenship  United States Citizen  Lawful Permanent Resident  Temporary Visitor  Undocumented Immigrant (for internal informational purposes only)

\* By giving us your cell phone number and email address, you are giving us permission and consent to contact you using those channels

\*\* By notifying us of your preferred language, we are not agreeing to send your materials in that language (for translation assistance, please call Member Services 800-538-5038)

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 Select Health/Select Health 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® (Select Health'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 Bud Mahas Construction GROUP # G1020433

SUBGROUP NAME Bud Mahas Construction SUBGROUP # A001

CLASS NAME ACTIVE : Bud Mahas Construction CLASS ID # AC01

HIRE DATE (MM/DD/YYYY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ EMPLOYEE'S MEDICAL PLAN EFFECTIVE DATE (MM/DD/YYYY) 01 / 01 / 2025

EMPLOYEE'S PAYROLL STATUS FullTime

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 \_\_\_\_\_  I do not want to buy health insurance at this time.  
INSURANCE COMPANY NAME
- I already have dental insurance through \_\_\_\_\_  I do not want to buy dental insurance at this time.  
INSURANCE COMPANY NAME

Employee Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**D. DEPENDENT INFORMATION**

Complete this section in full. List 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 Select Health).

NUMBER OF DEPENDENTS YOU ARE ENROLLING \_\_\_\_\_

**COVERAGE**

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

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

EYEWEAR SEX:  M  F RELATIONSHIP:  Spouse  Dependent

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

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

EYEWEAR SEX:  M  F RELATIONSHIP:  Dependent

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

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

EYEWEAR SEX:  M  F RELATIONSHIP:  Dependent

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

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

EYEWEAR SEX:  M  F RELATIONSHIP:  Dependent

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

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

EYEWEAR 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 \_\_\_\_/\_\_\_\_/\_\_\_\_