



UTAH SMALL EMPLOYER HEALTH INSURANCE APPLICATION

OFFICE USE ONLY	
Policy / Group No.	
Effective Date	
PEC	
New Hire Waiting Period	

REASON FOR ENROLLMENT (mark all that apply)		
<input type="checkbox"/> New Group	<input type="checkbox"/> Newborn*	<input type="checkbox"/> Loss of Coverage*
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Marriage*	<input type="checkbox"/> Court Order*
<input type="checkbox"/> New Hire*	<input type="checkbox"/> Divorce*	<input type="checkbox"/> Other:
<input type="checkbox"/> New Application	<input type="checkbox"/> Re-apply	<input type="checkbox"/> Dependent Addition
* Date of Event		
<input type="checkbox"/> COBRA / Utah mini-COBRA / Alternative Coverage for:		
<input type="checkbox"/> Employee <input type="checkbox"/> Dependent Employer Name:		
Length of COBRA continuation coverage: <input type="checkbox"/> 18 mos. <input type="checkbox"/> 36 mos. Other:		
Original Qualifying Event Date:	Qualifying Event Date:	Date of Event:

COVERAGE REQUESTED						
Coverage	Self	Spouse	Child(ren)	COBRA	Utah mini-COBRA	Alternative Coverage
Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A. EMPLOYER INFORMATION

Employer _____ Hire Date _____ Rehire Date _____
 Location _____ Is this a division? Yes* No *If "Yes," name of parent company _____

B. ENROLLEE INFORMATION

Name (Last) _____ (First) _____ (MI) _____ Job Title _____ Hrs/Week _____
 Marital Status Legally Married Single Divorced Widowed Domestic Partner
 Address _____ Apt. _____ City _____ State _____ Zip _____
 Home (or other) Phone (_____) _____ Business Phone (_____) _____
 Spouse's Employer _____ Spouse's Business (or other) Phone (_____) _____
 Driver's License Number: _____ Email Address: _____

C. ENROLLING SUBSCRIBER / SPOUSE / DEPENDENTS (attach separate sheet if necessary)

In the section below, list yourself and all eligible family members to be included under coverage.

	Social Security #	Name (Last, First, MI)	Date of Birth	Age	M/F	Weight	Height	Medical Coverage	Rx Coverage	HICN
Employee						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. 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.

D. WAIVER OF COVERAGE

- Complete this section for yourself (if waiving) and/or any of your eligible dependents for whom you are waiving coverage. You may not enroll dependents if you are waiving (except children subject to a Qualified Medical Child Support Order).
- If you decline enrollment in this plan for yourself and/or any of your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll the omitted individual(s) in this plan, provided that you request enrollment within 30 days after the other coverage of the individual(s) ends. ("Decline enrollment" includes omission of the individual from this application.) In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption (the **Special Enrollment Period**).
- Please complete type of insurance coverage for the employee and all eligible members who have other health insurance coverage by completing type of insurance [group, individual or other (Medicare, Medicaid, V.A., H.I.P., etc.)]
- All eligible family members must be listed in either Enrolling or Waiving Members section.

Names of persons waiving coverage. Include last name if different from enrollee. No nicknames, please.	Birth Date MM/DD/YYYY	Other Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Insurance		Insurance Carrier Name	Reason for Waiver
			Group	Individual		
Employee:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Spouse:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Children:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
		<input type="checkbox"/> Yes <input type="checkbox"/> No				
		<input type="checkbox"/> Yes <input type="checkbox"/> No				

E. CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health insurance coverage (including Medicare or Medicaid) in effect within 24 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 24 months, please indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that the carrier can determine whose coverage is Primary.

Enrolling Individual's Name (Non-Medicare)	Insurance Carrier (Including policyholder name, insurer name and phone number)	Date of Coverage Month/Day/Year		Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage (Check all that apply) <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
		From	To		
1.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
2.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
3.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
4.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
5.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
6.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical

MEDICARE: If you or any family members listed on this application have Medicare, is coverage Part A Part B Part D and please complete the following information. **Note: Please submit a copy of your Medicare ID card with this application.**

Enrolling Individual	Effective Date / /	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual Enrollment
Enrolling Individual	Effective Date / /	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual Enrollment

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous carrier. Submission of prior coverage information does not automatically waive any PEC limitation. However, you will be subject to an automatic PEC Waiting Period of up to 12 months until we receive evidence of prior coverage.

F. DISABILITY INFORMATION

Are you or any dependent(s) disabled? Yes No If yes, indicate first and last name(s). _____

Reason for disability: _____

Is the disabled dependent unable to perform routine daily functions for two weeks or more? Yes No

Have you or any dependent(s) filed workers' compensation claims or disability claims within the last five years? Yes No

If so, what is the status of the claims? _____

G. HEALTH STATEMENT

IF ANY OF THE BELOW CONDITIONS OR QUESTIONS ARE CHECKED "YES" PROVIDE DETAILS IN SECTIONS H. & I. ON THE FOLLOWING PAGE. The federal Genetic Information Nondiscrimination Act prohibits health issuers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic tests, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. Do not report genetic information on this form. However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

EACH QUESTION MUST BE CHECKED "YES" OR "NO." This health statement must be complete or the application will be returned. Inaccurate health information may result in the policy being cancelled retroactively. It is your responsibility to notify the carrier of any change in health status while application is pending.

Respond to the following questions:		YES	NO	Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following (cont.):		YES	NO
1	Pregnancy/Adoption: Are you, your spouse, or any dependent family member pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?			21	Female Reproductive Conditions/Disorders: Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, or pelvic inflammatory disease or any other disorder of the reproductive system?		
2	Pregnancy/Fertility Related Treatment: Are you, your spouse, or any dependent family member being treated for infertility, fertility evaluation or treatment (including medication), miscarriage, complications related to pregnancy (including premature births)?			22	Digestive Conditions/Disorders: Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, any other gallbladder or digestive disorder, hemorrhoids, polyps, or any other rectal disorder?		
3	Last Menstrual Period: Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period? If yes, provide date of last menstrual cycle on the following page.			23	Nervous, Mental and Behavioral: Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication?		
Within the past 12 MONTHS has any applicant:			YES	NO	Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:		
4	Prescriptions/Medications/Immunizations: Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?			24	Gout, arthritis, Rheumatoid arthritis, fibromyalgia, or scleroderma?		
5	Conditions Requiring Follow Up Medical Consult/Treatment: Do you, your spouse or any dependent family member have a condition for which hospitalization, tests, consultation, evaluation, surgery, or medication have been advised, but not completed?			25	Musculoskeletal Conditions/Disorders: Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis or other musculoskeletal disorder?		
6	Medical Consult/Treatment: Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?			26	Digestive Conditions/Disorders: Crohn's disease, Colitis, colostomy, or ileostomy or other digestive disorder?		
7	Conditions Requiring Initial Medical Consult/Treatment: Had a health condition, problem, disorder, or any other medical or mental health conditions not listed for which medical or mental health advice or treatment has <u>not</u> been sought ?			27	Alcohol or Drug Use/Abuse: been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption, drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?		
Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:			YES	NO	28	Eating Disorders/Obesity Treatment: including bulimia, anorexia, or obesity and any surgical services for obesity.	
8	Urinary, bladder, incontinence, kidney or liver conditions or disorders? Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?			29	Respiratory Conditions/Disorders: RSV, reactive airway disease, tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, emphysema?		
9	Neurological Disorders: Recurring headaches, migraines, head injury, epilepsy, seizures, or convulsions or other neurological disorder?			30	Tobacco use (chewing or smoking)? Quit Date: _____		
10	Metabolic and Endocrine Conditions/Disorders: Lupus, thyroid disorder, goiter, or any other lymph system disorder?			Has any applicant EVER been diagnosed with or treated for any of the following:			
11	Eyes, ears, nose, sinus, or throat conditions/disorders or any other respiratory system disorder including allergies or hay fever?			31	Transplant or Implanted Device: Any organ or tissue transplant, pacemaker or other implanted device?		
12	Skin Conditions/Disorders: Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?			32	Nervous, Mental and Behavioral: Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?		
13	Breast Conditions/Disorders: Breast lumps, breast augmentation, or breast reduction?			33	Birth Defects/Congenital Abnormalities: premature birth, development or learning disability, mental impairment, Down syndrome, or autism spectrum disorder?		
14	Heart Conditions/Disorders: Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?			34	Heart and Circulatory Conditions/Disorders: Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, or coronary artery disease, or congestive heart failure?		
15	Back, neck, bone, joint or spinal disorder: bone or joint disorders (including foot, knee, jaw, fracture, dislocation or joint replacement)?			35	Brain/Nervous System Conditions/Disorders: Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?		
16	Blood Conditions/Disorders: Hemophilia, anemia, blood or bleeding disorder?			36	Diabetes (type I or II), insulin resistance?		
17	Male Reproductive Conditions/Disorders: Impotence, prostate or testicular disorder, or abnormal PSA or other reproductive disorder?			37	Immune System Conditions/Disorders: Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?		
18	Circulatory System Conditions/Disorders: Varicose veins, or any other circulatory disorder?			38	Cancer/Tumors: (including skin cancer or melanoma) or tumors?		
19	Hospitalization/Surgery: Have you, your spouse or any dependent family member been hospitalized or had surgery?			39	Urinary/Liver Conditions/Disorders: Cirrhosis, hepatitis, or renal failure?		
20	Sexually transmitted diseases?			OTHER MEDICAL INFORMATION			
				40	Any medical condition or treatment that you are unsure of where it fits in above?		

J. ACKNOWLEDGMENT AND SIGNATURE

I agree to abide by the Plan's enrollment provisions. I understand that coverage cannot start until after I have served the waiting period agreed to by the employer as recorded on the Plan's records. I authorize my employer to act as my agent in all matters of administration of the group program, and acknowledge that my employer is in no way acting as agent for the Plan.

I understand there may not be participating providers in all specialty fields.

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for those individual(s) listed in the WAIVING MEMBERS section above (or any eligible family member not listed). In waiving coverage, I am aware that waiving members (including myself, if I am waiving) may not enroll until my group's anniversary, unless the waiving member qualifies for a Special Enrollment Period (SEP). If I have waived enrollment for myself or any of my dependents (including my spouse) because of other health insurance or group health plan coverage, I may in the future be qualified for a SEP and be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that credit for prior coverage will be based upon the information contained in this application. If any information provided is false or incomplete, the Plan and/or its subsidiaries may without advance notice declare the contract null and void and cancel the coverage retroactive to its original effective date or impose the pre-existing condition waiting period and deny claims that are pre-existing.

I further certify that all information completed on this form is true, correct and complete and acknowledge my coverage is subject to cancellation or other action permissible at law, if any completed information is found to be false or incorrect.

Any matter in dispute between myself and the Plan may be subject to arbitration as an alternative to court action pursuant to the rules of the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration, including, but not limited to: attorney fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both myself and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

I attest that all information on this form is accurate. I have read the Acknowledgment of this document and agree to its terms. I have also completed the Authorization to Disclose Protected Health Information form that accompanies this application.

Subscriber Signature _____ Date _____



P.O. Box 30192, Salt Lake City, UT 84130-0192 801-442-5038/800-538-5038 www.selecthealth.org

NationCare Utah Application Supplement Form Small Employer

January
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This form must accompany the Utah Small Employer Health Insurance Application.
For instructions regarding this form, please refer to section "E" on page 2.

Applicant's Name _____ Employer _____

A. MEDICAL PLAN INFORMATION

SELECT ONE FROM EACH OF THE FOLLOWING (BASED ON THE PLAN DESIGN SELECTED BY YOUR EMPLOYER):

1 - Open Panel-NationCare—If your employer has chosen the Open

Panel-NationCare option, select the following plan option:

NationCare

2 - HealthSaveSM-NationCare—If your employer has chosen the

HealthSave-NationCare option, select the following plan option:

NationCare

3 - Dual Option-NationCare—If your employer has chosen Dual

Option-NationCare, select one of the following plan options:

HSA-Compatible Plan PPO Plan

B. DENTAL COVERAGE

Yes, I would like SelectHealth Dental[®] coverage.

Complete section "B1."

No, I would not like SelectHealth Dental coverage.

Complete section "B2."

B1. SELECTHEALTH DENTAL BENEFIT SECTION

EMPLOYEE AND DEPENDENT INFORMATION (List yourself and eligible dependent(s) to be covered below)

RELATIONSHIP	NAME (FIRST, MIDDLE INITIAL, LAST)	SEX	DATE OF BIRTH (MM/DD/YY)	AGE	SOCIAL SECURITY NUMBER	OTHER DENTAL INS.	NAME OF OTHER DENTAL INSURANCE CARRIER
EMPLOYEE		M/F				Y/N	
SPOUSE		M/F				Y/N	
CHILD		M/F				Y/N	
CHILD		M/F				Y/N	
CHILD		M/F				Y/N	
CHILD		M/F				Y/N	
CHILD		M/F				Y/N	

B2. WAIVER OF SELECTHEALTH DENTAL BENEFITS

Other Dental Carrier _____ Subscriber ID# _____ Policy Type Group Individual

Policyholder's Name _____ Relationship to Policyholder _____

C. EMPLOYEE SIGNATURE

Employee Signature _____ Date Signed ____/____/____

D. AUTHORIZATION AND ACKNOWLEDGMENT

I hereby apply to be enrolled with my listed eligible dependent(s), if applicable, for coverage with NationCare. In connection with both this form 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 SelectHealth/Fidelity Life Association, a Legal Reserve Life Insurance Company, 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 Fidelity Life Association. I also understand no coverage will be in force until each person listed is approved by SelectHealth, that no benefits will be provided for any service which begins before coverage is effective, and that except as expressly provided in 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 form is true and complete. I understand that omissions or intentional misrepresentations regarding information provided on this form could cause an otherwise covered service to be denied and/or void any coverage issued.

CONSENT AT ENROLLMENT. I understand that my choice of healthcare 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 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 form is correctly recorded, true, and complete. If I subsequently become aware of information different from that provided on this form, I agree to provide that additional information promptly to SelectHealth.

E. ENROLLMENT INSTRUCTIONS AND ADDITIONAL INFORMATION

You must read Section "D. Authorization and Acknowledgment" before signing this form. It contains policy and terms for agreement. All areas of the form should be completed in detail by you. It is your responsibility to read and understand this information and follow the instructions given. Please print legibly in ink. Illegible or incomplete applications will delay processing. The following instructions will help you complete this form. If you need further help, contact your employer, SelectHealth-appointed insurance agent, or a SelectHealth representative at **801-442-4908, option 2** or **800-442-3125, option 2**.

COMPLETE AND SIGN THE UTAH SMALL EMPLOYER HEALTH INSURANCE APPLICATION FORM

Applications 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 or marriage certificate. A Certificate of Creditable Coverage (to prove involuntary loss of other coverage) must be submitted as soon as reasonably possible.

EMPLOYEE AND DEPENDENT INFORMATION (Sections "B" and "C" on Utah Small Employer Health Insurance Application form)

Complete this section with all of the requested information about you and/or your dependent(s). If your spouse is enrolled, 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).

To be eligible for coverage, children must be younger than age 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.

CURRENT/PRIOR COVERAGE INFORMATION (Section "E" on Utah Small Employer Health Insurance Application form)

For coordination of benefit purposes, complete this section to indicate whether or not each member will be covered by other medical insurance while this health plan is in force.

NOTE: You must list other health insurance information for each member applying for coverage in order for SelectHealth to coordinate benefits with other carriers when necessary.

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 SelectHealth proof of prior coverage, such as a Certificate of Creditable Coverage, for each member. You have the right to request a Certificate of Creditable Coverage from your prior carrier. If necessary, SelectHealth will assist in obtaining such Certificates.

COMPLETE AND SIGN THE NATIONCARE UTAH APPLICATION SUPPLEMENT FORM (SMALL EMPLOYER)

You must read Section "D. Authorization and Acknowledgment." If you read, understand, and agree to the terms stated, sign and date section "C."