UTAH INDIVIDUAL HEALTH INSURANCE APPLICATION

Only for use outside the Federally Facilitated Marketplace

A. APPLICANT INFORMATION

Please check one of the following boxes: ❒ New Application ❒ Dependent Addition

Name (Last) _____ (First) _____ (MI) _____

Marital Status ❒ Legally Married ❒ Single ❒ Divorced ❒ Widowed ❒ Domestic Partner*

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Street Address _____ Apt. _____ City _____ State _____ Zip _____

Applicant's county of residence: _____

Home/Cell Phone (_____) _____ Business Phone (_____) _____

Driver's License Number: _____ Email Address: _____

Are all persons applying for coverage a U.S. citizen or U.S. national? ❒ Yes ❒ No If no, provide name(s):_____

If a person applying for coverage is not a U.S. citizen or U.S. national, do they have eligible immigration status? ❒ Yes ❒ No

If yes, provide your document type and ID number below.

Immigration document type: _____ Document ID number: _____

Lived in the U.S. since 1996? ❒ Yes ❒ No Veteran or an active-duty member of the U.S. military? ❒ Yes ❒ No

Is any person applying for coverage incarcerated or jailed? ❒ Yes ❒ No If yes, provide name(s):_____

B. APPLICANT AND DEPENDENT INFORMATION

In the section below, list yourself and all eligible family members to be included under the policy. 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 unless the child meets the requirements of children with a disability. Any dependent not listed will not be considered for coverage. Attach a separate sheet if necessary.

	Name(Last, First, MI)	Social Security # (for insurer use only)	Date of Birth MM/DD/YYYY	Gender	Tobacco Use
Self				❒ Male ❒ Female	❒ Yes ❒ No
Spouse/ Domestic Partner*				❒ Male ❒ Female	❒ Yes ❒ No
Dependent				❒ Male ❒ Female	❒ Yes ❒ No
Dependent				❒ Male ❒ Female	❒ Yes ❒ No
Dependent				❒ Male ❒ Female	❒ Yes ❒ No

*Check with your employer to determine if domestic partner coverage is available.

Does any listed proposed insured live, reside, work or attend school outside the state of Utah at any time during the year? ❒ Yes ❒ No

If yes, name of proposed insured and % of time outside the state: _____

C. CURRENT COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, including Medicare or Medicaid, currently in effect. This information will be used to determine if benefits will be coordinated. If no health care coverage was in effect, 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 dependents' health care coverage so that the insurer can determine whose coverage is primary. Attach a separate sheet if necessary.

Name of Individual	Insurer (List policyholder name, insurer name and phone number)	Date of Coverage MM/YY Start Date	End Date	Will coverage continue?	Type of Coverage (Check all that apply)
Applicant:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____
Spouse/ Domestic Partner:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____
Dependent:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____
Dependent:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____
Dependent:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____

D. EMPLOYMENT INFORMATION

Employer _____ Group Insurer _____ Job Title _____ Hrs/Week _____
Spouse's Employer _____ Spouse's Group Insurer _____ Spouse's Job Title _____ Hrs/Week _____

1. Is any employer reimbursing or paying for any portion of this policy? ❒ Yes ❒ No
2. Does your employer offer health insurance? ❒ Yes ❒ No
3. Are you self-employed? ❒ Yes ❒ No If self-employed, do you have any full or part-time employees? ❒ Yes ❒ No

E. ACKNOWLEDGMENT & SIGNATURE

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage. When incorporated with the policy, this application will become part of the policy. Once fully signed and executed, insurer and I agree to terms set forth in the policy. In connection with both this application and any coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable eligibility criteria. I also understand that no benefits will be provided for any services which begin before the policy is effective; and that except as expressly provided in the policy, benefits will not extend beyond the termination of either my coverage or the policy.

CONSENT AT ENROLLMENT.
I understand that it is my continuing responsibility to report to the insurer changes in the eligibility of any applicants who become enrolled.

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 policy.

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

I agree that coverage for any services that are obtained without or contrary to required preauthorization/precertification requirements in the policy may be denied

NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH BENEFIT PLAN.
According to information furnished, you may intend to lapse or otherwise terminate an existing health benefit plan and replace it with a new policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

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 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 the insurer. A change of information prior to the effective date of the policy may void an offer to provide coverage.** If any information provided is false or incomplete, the insurer may without advance notice pursue any remedies available under state or federal law, including but not limited to: declaring the policy null and void and canceling the policy retroactive to its original effective date.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER 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 INSURER. THE INSURER 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 YOU AND THE COMPANY. 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.

Applicant Signature _____ Date _____
(A faxed signature shall be valid as an original signature.)

Spouse/Domestic Partner Signature _____ Date _____
(Required if applying for coverage. A faxed signature shall be valid as an original signature.)

Requested Effective Date _____
(Coverage is not in force until the insurer approves your application and determines the effective date.)