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selecthealth

Application Supplement Form Utah Small Employer

Employer Name ML SPAS LLC **Employee Name** _____

MEDICAL PLAN INFORMATION

☐ YES I would like medical coverage from SelectHealth. I choose plan option # _____
(Choose from plan options selected by your employer)

Please select from one of the following network options:

☐ SelectHealth Med
☐ SelectHealth Value

I would like to enroll in a Health Savings Account (HSA) administered by HealthEquity ☐ Yes ☐ No

☐ NO I would not like medical coverage from SelectHealth (please complete and sign the **WAIVER OF COVERAGE** in the *Utah Small Employer Application*).

AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby authorize enrollment of myself and my listed eligible dependent(s), if applicable, for coverage with SelectHealth/SelectHealth Benefit Assurance Company (SHBAC), 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 SelectHealth/SHBAC, I appoint my employer to act as an agent on behalf of myself and my dependent(s). I understand that coverage is dependent upon the satisfaction of applicable criteria and is subject to the terms and conditions of my employer's Contract with SelectHealth/SHBAC. I also understand no coverage will be in force until each person listed is approved by SelectHealth/SHBAC, that no Benefits will be provided for any service that begins before coverage is effective, and that except as expressly provided in my employer's Contract with SelectHealth/SHBAC, Benefits will not extend beyond the termination of either my coverage or my employer's Contract with SelectHealth/SHBAC. I represent that all information provided on this Application 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 coverage.

CONSENT AT ENROLLMENT, I understand that my employer's Contract with SelectHealth/SHBAC may limit the Providers whose services will be covered. I understand that my employer's Contract with SelectHealth/SHBAC limits or excludes certain conditions and services from coverage. I agree that to the extent I do not abide by the terms of my employer's Contract with SelectHealth/SHBAC, services I obtain may not be covered. If my employer's Contract with SelectHealth/SHBAC requires 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 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 SelectHealth/SHBAC.

SIGNATURE

Employee Signature _____ **Date Signed** ____ / ____ / _____