2024 Health Insurance

APPLICATION FOR INTERMOUNTAIN HEALTH RETIREES

Please complete and email this form to AskHR@imail.org

Intermountain Health
5245 South College Drive
Salt Lake City, UT 84123
833.442.7547

APPLICANT Information

Applicant name (First, Middle, Last)	**Social Security Number**	**Retirement Date**
Address	**Phone number**	
City	**State**	**ZIP Code**
Email address	**Date of birth**	

PLAN Choice (check one only)

☐ Select Care Plus HDHP ☐ Select Med Plus HDHP ☐ Select Care Plus $750

HealthSave – Select Care Plus
$1,600/$3,200 deductible (in-network)
$1,750/$4,500 deductible (out-of-network)

2024 Monthly Premium

Points	85+	75-84	<75
Retiree	**$1,164**	**$1,280**	**$1,330**
Retiree/spouse	**$2,510**	**$2,774**	**$2,801**
Addtn'l child	**$266**	**$266**	**$266**

HealthSave – Select Med Plus
$1,600/$3,200 deductible (in-network)
$1,750/$4,500 deductible (out-of-network)

2024 Monthly Premium

Points	85+	75-84	<75
Retiree	**$1,095**	**$1,211**	**$1,261**
Retiree/spouse	**$2,359**	**$2,623**	**$2,650**
Addtn'l child	**$254**	**$254**	**$254**

Select Care Plus
$750/$2,000 deductible (in-network)
$1,000/$3,000 deductible (out-of-network)

2024 Monthly Premium

Points	85+	75-84	<75
Retiree	**$1,316**	**$1,432**	**$1,482**
Retiree/spouse	**$2,840**	**$3,104**	**$3,131**
Addtn'l child	**$296**	**$296**	**$296**

COVERAGE Requested

Individual ☐ **Double** ☐ **Family** ☐

COVERED Participants

Relationship to retiree	**Names of participants to be covered**	**Social Security #**	**Gender**	**Date of birth** (month, day, year)	**Name of other health insurance carrier and policy #**
Retiree				/ /	☐ YES ☐ NO
Spouse				/ /	☐ YES ☐ NO
Child				/ /	☐ YES ☐ NO
Child				/ /	☐ YES ☐ NO

SIGNATURE OF SUBSCRIBER MUST BE COMPLETED BELOW TO VALIDATE APPLICATION. On the reverse side of this application, terms and conditions are listed which are an integral part of your application for benefits. Please read those provisions carefully. By signing, you acknowledge that you have read and understand the provisions of this plan including those contained on the reverse side of this form.

Subscriber signature:_____ **Date:** _____

WAIVER OF COVERAGE ☐ I wish to discontinue my health insurance benefits. I choose not to participate in these health insurance benefits for myself, my dependent(s) or my heirs, and hereby waive such coverage. I understand I will never have another opportunity to enroll.
Subscriber signature:_____ Date: _____

EMPLOYER USE: Coverage code:_____ **Effective date/retiree coverage**_____ **Pension Connect Input** ☐
SH Link Input ☐ **Intermountain authorization**_____**Date**_____**Points:**_____
Code:_____ **Premium:** _____

Terms and conditions of application

I hereby apply for membership in the Intermountain Retiree Medical Insurance Program (the "Plan") for the persons listed on this application (herein referred to as applicants) and agree to submit Prepayment Fees as required by the Plan or authorize my employer to deduct the necessary contributions from my Intermountain Pension Plan benefit check. I accept the terms of the group agreement between my previous employer and SelectHealth and appoint my previous employer to act as agent in my behalf. I understand that said agreement is on file with my previous employer or the Plan and is available for my inspection. I understand that any material misrepresentation in answering the questions on this application or nonpayment of prepayment fees, deductible, coinsurance, or copayments may result in rescission or cancellation of my coverage and/or that of my dependents.

I represent all information on this application is true. I authorize the Plan, any physician, dentist, medical practitioner, hospital, clinic, any other provider of health or dental care, insurance company or person to disclose to SelectHealth or its representatives or providers all information and records of the applicants relating to coverage, diagnosis, treatment, medical history, physical or mental conditions and evaluations thereof for which medical coverage is sought.

I understand that no agent or Plan representative is allowed to permit me to answer any question inaccurately, untruthfully, or incompletely and I represent that such did not occur. I understand that it is my continuing responsibility to report to SelectHealth any change in the eligibility of any applicants who become members.

I agree that any claim or dispute, including claims for bodily injury or death of a member, asserted by a member, his/her dependents, assigns, heirs or personal representative, against SelectHealth, its agents or employees is subject to binding arbitration. This is true unless my employer is providing this health benefit program to its employees on a self-funded basis, and if in such case, my employer has provided another method through which such claim or dispute is to be resolved, then I agree to submit any such claim to that means of dispute resolution.

I understand that coverage under an Intermountain sponsored medical plan for the six months immediately preceding retirement is required for enrollment. If I enroll, I will be expected to pay the cost for such benefits. If I waive coverage, no opportunity to enroll will be available later. Reasonable efforts will be made to keep employees informed of any changes in the benefit plans. However, Intermountain reserves the right to amend, replace and/or terminate any or all of the plans or any of the benefits provided without prior notice to retirees. Intermountain also reserves the right to adjust retiree health insurance premium costs as necessary.

Note: My spouse and dependent children over the age of eighteen, if any, have authorized me to sign the above release in their behalf.