motivhealth™

MotivHealth Insurance Company
PO Box 709718
Sandy, UT 84070-9718
www.motivhealth.com

Hire Date: _____

Coverage Effective Date: _____

MotivHealth Insurance: Employee Enrollment Form

Employer: _____

Employee: _____ Email Address: _____

Address: _____ City: _____

ST: _____ Zip: _____

Preferred Phone: _____ Other Phone: _____

Preferred Method of Contact: ___ Phone ___ Email ___ Text

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

RELATIONSHIP	NAME (First, Middle Initial, Last)	SEX	DATE OF BIRTH (MM/DD/YY)	AGE	SOCIAL SECURITY #
EMPLOYEE		M/F			
SPOUSE		M/F			
CHILD		M/F			
CHILD		M/F			
CHILD		M/F			
CHILD		M/F			
CHILD		M/F			

MotivHealth Insurance: Plan Selection

Deductible Individual _____ Deductible Family _____

Individual Maximum Out of Pocket _____ Family Maximum Out Of Pocket _____

Coinsurance _____ Copayments _____

Rx cost sharing _____

IN NETWORK

Health Savings Account (HSA): ❑ Yes, set up my HSA ❑ No, do not set up an HSA for me

CONSENT TO ELECTRONIC DISTRIBUTION

By my signature below and unless I have expressly rejected electronic distribution by marking the checkbox below, I consent, on behalf of myself and any covered dependents, to the electronic distribution of communications related to the coverage applied for and understand that:

To access electronically distributed communications, I and each of my covered dependents will need to establish motivhealth.com accounts for use on a system meeting the outlined requirements and I represent that we each have and will continue to have access to such a system or systems.

Not all member communications are currently available electronically, but agree that my consent will apply to the following materials available, or as they become available, for electronic distribution, (i) notices of enrollment and/or effective date, (ii) acknowledgments of receipt of claims, requests for additional information related to claims and notices of associated delays in processing, and determinations on submitted claims, (iii) general informational disclosures required by law, including but not limited to notices of rights under the Women's Health and Cancer Rights Act, state patient protection acts, and privacy laws, (iv) communications regarding complaints, grievances, or appeals, including but not limited to acknowledgments of receipt, requests for additional information and notices of associated delays, and notices of determinations, (v) summaries of benefits and coverage and uniform glossary of terms, (vi) notices of benefit changes or policy modifications, (vii) renewal information, (viii) notices of discontinuation, (ix) notices of termination and continuation coverage rights, (x) certificates of creditable coverage, (xi) billing notices and statements.

Until a type of communication can be distributed electronically, a paper copy will be provided.

Once available in electronic form, any electronically distributed communications may be printed from the motivhealth.com account where they are posted, or a paper copy of any particular communication may be requested at any time using motivhealth.com or by contacting MotivHealth Insurance Company's Customer Service at the number provided on my ID card.

I may change the e-mail address for receipt of notice of electronic distributions or withdraw consent (returning to paper distribution) at any time and without charge using motivhealth.com or by contacting HSA Health Plan Customer Service as described in the previous bullet.

❑ I do not want electronic distribution. Unless my consent is not required for an electronic distribution, I elect to receive communications related to this coverage in a paper format.

Authorization and Acknowledgment

I hereby apply for health insurance coverage from MotivHealth Insurance Company for the persons listed on this application and agree to submit premiums as required by MotivHealth Insurance Company 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 MotivHealth Insurance Company and appoint my employer to act as an agent on my behalf.

I understand that said agreement is on file with the employer and MotivHealth Insurance Company 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 other listed on this application. I agree to pay cost sharing required through any policy issued as part of this application. I authorize MotivHealth Insurance Company to receive information regarding any health issues and any claims related to this policy.

I understand that the Group Health Insurance Contract may limit the healthcare providers whose services will be covered. I understand that the Group Health Insurance Contract limits or excludes certain conditions or services to myself or others included on this application. I agree that to the extent I do not abide by the terms of the Group Health Insurance Contract, healthcare services I obtain may not be covered. If the Group Health Insurance Contract provides that contributions be made, I authorize my employer to deduct them from my pay. If indicated in the plan selection, I authorize MotivHealth Insurance Company to establish an HSA. By establishing an HSA, I attest that I am not covered under other health insurance policy that would make me ineligible to establish an HSA and I am not enrolled in Medicare.

Check This Box to Decline Coverage

☐ By checking this box, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage.

Employee Signature Date