



EMI Health
5101 S. Commerce Dr.
Murray, Utah 84107
801-262-7475

UTAH SENIOR INDIVIDUAL DENTAL & VISION - WEBSITE

Plans underwritten or operated by Educators Health Plans Life, Accident and Health

APPLICANT INFORMATION

Full Name (First, M.I., Last)

Street Address

City County State Zip Code

Phone Number ( ) Email Address

Birth Date (mm/dd/yyyy) / / Age Gender (M / F)

Social Security Number - -

If you intend to cover a spouse - please complete.

Covered Spouse Full Name (First, M.I., Last)

Birth Date (mm/dd/yyyy) / / Age Gender (M / F)

Social Security Number - -

Do you or your dependent to be covered on this plan have other dental insurance? Yes No

a) If Yes, who is the subscriber/policy holder?

b) Name of other insurance company/dental carrier

DENTAL PLAN SELECTION

VISION PLAN SELECTION

SENIOR CHOICE PPO - HIGH

SENIOR CHOICE PPO - LOW

VISION 10-210

Single - \$37.00

Single - \$30.00

Single - \$14.00

Couple - \$66.00

Couple - \$52.00

Couple - \$28.00

Requested Effective Start Date (mm/dd/yyyy) / /

I wish to enroll in the EMI Health Senior Dental and/or Vision plan(s) checked above. In signing this application, I understand that the premiums are my responsibility. I understand that I am responsible to notify EMI Health if there are any changes in my status regarding dental coverage and also agree to remain in the plan for a minimum of one year.

# EMI Health Utah Senior Individual Dental & Vision Application

## **PAYMENT OPTIONS** — Please select a payment option.

- Receive a monthly bill (direct billing)
- Electronic Funds Transfer (EFT) directly from your account each month. Please provide the following information and include/attach a VOIDED check.

Account Type       Checking       Savings

Account Holder \_\_\_\_\_ Signature \_\_\_\_\_

Routing # \_\_\_\_\_ Account # \_\_\_\_\_

By signing above I hereby authorize EMI Health to withdraw my total monthly premium payment on or about the first day of each month, for the following month's premium, as indicated above. The authority is to remain in effect until EMI Health has received written notification from me for 30 days prior to the next scheduled payment, or until I receive written notification of termination from EMI Health. Failed withdrawals will be subject to an additional administrative fee.

## **PRODUCER INFORMATION** — To be completed by Producer when applicable.

I, (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by EMI Health. I have informed the applicant that the effective date of coverage is assigned only by EMI Health.

## **I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.**

Producer Name \_\_\_\_\_ EMI Health Producer Number \_\_\_\_\_

Producer Signature \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

## **ELECTION TO PARTICIPATE**

### **THE POLICY PROVIDES DENTAL AND VISION BENEFITS ONLY. REVIEW YOUR POLICY CAREFULLY.**

I apply for coverage to which I may be entitled under the terms of the policy, including binding arbitration provisions, issued by EMI Health. The proposed coverage shall not take effect until this application has been accepted by the underwriting company. Coverage under the policy begins on the applicable effective date as stated on the face page of the policy, which will be delivered to me through the U.S. Postal Service. I understand that I am not entitled to change my coverage elections during the policy year. I authorize EMI Health to share medical information concerning me or my family with any healthcare provider providing health benefits within the scope of the policy. I understand that any person who includes any false misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signature \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

*The proposed coverage shall not take effect until this application has been accepted by EMI Health. Coverage under the Policy begins on the applicable effective date as stated on the face page of the Policy, which will be delivered to the Subscriber through the US Postal Service.*