EMI Health
852 East Arrowhead Lane
Murray, Utah 84107
800-662-5850

UTAH SENIOR INDIVIDUAL DENTAL

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 _____

PLAN SELECTION

❑ **SENIOR ADVANTAGE CO-PAY**
- ❑ Single - $20.00
- ❑ Couple - $35.00

❑ **SENIOR CHOICE PPO - LOW**
- ❑ Single - $28.00
- ❑ Couple - $49.00

❑ **SENIOR CHOICE PPO - HIGH**
- ❑ Single - $35.00
- ❑ Couple - $62.00

❑ **VALUE DISCOUNT DENTAL PROGRAM** - This is a discount program, not an insurance policy.
- ❑ Single - $6.00
- ❑ Couple - $9.00

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

I wish to enroll in the EMI Health Senior Dental plan 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 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 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.