EMI HEALTH™

ARIZONA GROUP APPLICATION

5101 S. Commerce Drive • Murray, Utah 84107 • 801-270-2967 • www.emihealth.com

EMPLOYER INFORMATION

EMPLOYER'S NAME	TAX IDENTIFICATION NUMBER (TIN)	SIC CODE AND / OR NATURE OF BUSINESS
ADDRESS	CITY & STATE	ZIP CODE
BILLING ADDRESS (IF DIFFERENT THAN ABOVE)	CITY & STATE	ZIP CODE
MEMBERSHIP / ADMIN CONTACT - NAME & TITLE	PHONE	FAX
BILLING CONTACT - NAME & TITLE (IF DIFFERENT THAN ABOVE)	PHONE	FAX
MEMBERSHIP / ADMIN CONTACT - EMAIL ADDRESS	BILLING CONTACT - EMAIL ADDRESS	REQUESTED EFFECTIVE DATE
HSA / HRA / FSA ADMINISTRATOR	HSA BANK (IF ANY):	NUMBER OF FULL-TIME EMPLOYEES (30+ HRS PER WEEK):
ELIGIBILITY FOR NEW ENROLLEES First day of the month following _____ days of continuous full-time employment.	ELIGIBILITY FOR LEGAL GUARDIANSHIP ❑ YES, ELIGIBLE FOR COVERAGE ❑ NO, INELIGIBLE FOR COVERAGE	ELIGIBILITY FOR DOMESTIC PARTNERS ❑ YES, ELIGIBLE FOR COVERAGE ❑ NO, INELIGIBLE FOR COVERAGE

COBRA ADMINISTRATION

DO YOU HAVE 20 OR MORE W2 EMPLOYEES (INCLUDING PART-TIME?) ❑ Yes ❑ No	IF YES, WOULD YOU LIKE EMI HEALTH TO ADMINISTER COBRA? ❑ Yes ❑ No; Administrator _____	IF NO, WOULD YOU LIKE EMI HEALTH TO ADMINISTER STATE CONT. COVERAGE? ❑ Yes ❑ No

***Attach census if EMI Health will be administering COBRA. Option must be made at the time of application; no changes will be allowed after acceptance of application.**

BENEFITS See quote or RFP response for participation requirements

❑ MEDICAL (CONTRIBUTORY ONLY)

Employer's contribution for employee _____
Employer's contribution for dependent _____
Number waiving coverage _____

❑ Fully-Insured Care Plus
❑ Modified Care Plus
❑ Self-funded Care Plus

❑ Minimum Essential Coverage (MEC)*
Employer's contribution for employee _____
Employer's contribution for dependent _____
*This MEC Plan does not meet ACA Minimum Value requirements.

❑ VISION

❑ Voluntary ❑ Contributory

Employer's contribution for employee _____
Employer's contribution for dependent _____
Number waiving coverage _____

❑ VSP ❑ VSP Plus Plan ID#: _____

❑ DENTAL

❑ Voluntary ❑ Contributory
❑ Self-funded ❑ Fully-insured

Employer's contribution for employee _____
Employer's contribution for dependent _____
Number waiving coverage _____

❑ Advantage Co-Pay
❑ Advantage Plus Indemnity
❑ Advantage Plus PPO
❑ Choice Indemnity
❑ Choice PPO
❑ Value Discount Program (not an insurance product)
❑ Premier Co-Pay
❑ Premier Indemnity
❑ Premier PPO
❑ Summit Indemnity
❑ Summit PPO
❑ Summit Plus PPO
❑ Summit Plus Indemnity

MEDIA RELEASE

On occasion, EMI Health may issue a press release announcing new business. Do you grant permission for your company name to be mentioned in such a release? ❑ Yes ❑ No

ENROLLMENT SUMMARY

PLAN	THREE TIER	FOUR TIER	NUMBER OF ENROLLEES	RATE	TOTAL PREMIUM
	Employee	Employee			
	Two-party	Employee/Spouse			
		Employee/Child(ren)			
	Family	Family			
	Employee	Employee			
	Two-party	Employee/Spouse			
		Employee/Child(ren)			
	Family	Family			
	Employee	Employee			
	Two-party	Employee/Spouse			
		Employee/Child(ren)			
	Family	Family			
	Employee	Employee			
	Two-party	Employee/Spouse			
		Employee/Child(ren)			
	Family	Family			
		Premium Subtotal			
		Dental Monthly Administrative Fee ($2.00 per employee, $20.00 maximum) waived if ACH.			
		Total First Month's Premium (must be included with this application)			

Attach additional Enrollment Summary sheet if necessary.

SIGNATURES

By signing below, the authorized person attests that he or she:

- understands that participating providers are not agents, representatives, nor employees of EMI Health, nor its affiliates (EMI Health).
- represents that all information on this application and any attachment is correct and complete to the best of his or her knowledge and that the discovery of any intentional material misrepresentation shall result in the termination of the policy.
- understands that no insurance will become effective until approved by EMI Health.
- understands that no agent has the authority to modify or waive any conditions of this application tor policy, nor to bind EMI Health, by making any promise or representation.
- agrees to maintain and furnish any records necessary for the efficient administration of the policy.
- understands that only those employees who meet eligibility requirements are to be covered under the policy and that participation and contribution requirements must be met before this policy will become effective and that such requirements must be maintained while the policy is in force to prevent termination of the policy.
- understands that coverage under the policy can be terminated in accordance with its terms and conditions.

I hereby request insurance for eligible persons based on the information provided on this application and any attachment, and where applicable agree to be bound by the terms and conditions of any trust agreement establishing a trustee as policyholder. I understand that insurance will not go into effect until the required premium is paid for the benefits selected.

Authorized Person's Signature _____ Date _____

Printed Name _____ Title _____

Agent Name _____ Agent Phone Number _____

Agency Name _____ Agent E-mail Address _____

For EMI Health's Use Only

Approved by _____ Date _____