EMI HEALTH™
Smart Benefits

ARIZONA GROUP APPLICATION

852 East Arrowhead Lane • Murray, Utah 84107-5298 • 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
PHONE	FAX	EMAIL	
BILLING ADDRESS		CITY & STATE	ZIP CODE
BILLING EMAIL ADDRESS			NUMBER OF FULL-TIME EMPLOYEES (AT LEAST 30 HOURS PER WEEK)
MEMBERSHIP / ADMINISTRATIVE CONTACT - NAME AND TITLE		HSA / HRA / FSA ADMINISTRATOR	HSA BANK (IF ANY)
REQUESTED EFFECTIVE DATE	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

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 ASC Care Plus
- ☐ Self-funded Care Plus
- ☐ Minimum Essential Coverage (MEC)

☐ 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
- ☐ Premier Co-Pay
- ☐ Premier Indemnity
- ☐ Premier PPO
- ☐ Value Discount Program (not an insurance product)

COBRA ADMINISTRATION

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

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)			
		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.
- 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