EMI HEALTH™
Smart Benefits

☐ **ENROLLMENT APPLICATION** (Complete entire application.)
☐ **CHANGE FORM** (Complete shaded boxes and all changed information.)

EMI Health • 852 East Arrowhead Lane • Murray, Utah 84107-5298 • 801-262-7475

EMPLOYER	SPECIFIC JOB TITLE	DATE OF EMPLOYMENT	POLICY NUMBER (FOR OFFICE USE ONLY)
LAST NAME FIRST INITIAL	EMPLOYEE SOCIAL SECURITY NO.	EMPLOYEE DATE OF BIRTH	E-MAIL ADDRESS
ADDRESS/STREET NO.	CITY & STATE ZIP CODE	HOME PHONE BUSINESS PHONE	
BENEFICIARY	RELATIONSHIP	CONTINGENT BENEFICIARY	RELATIONSHIP

EMPLOYMENT STATUS: ☐ ACTIVE EMPLOYEE ☐ RETIRED (RETIREMENT DATE / /) ☐ COBRA

OTHER INSURANCE INFORMATION (THIS SECTION MUST BE COMPLETED)

Do you, your spouse, or dependents have other medical or dental coverage (including Medicare)? ☐ Yes ☐ No
If so, what type of coverage? ☐ Medicare Part A ☐ Medicare Part B ☐ Other Medical ☐ Dental
If so, what is the coverage classification? ☐ Single ☐ Couple ☐ Family
Name of Insured _____
Insured's Social Security Number _____
Name of Other Insurance Company _____
Please provide any of the following information you may have:
Group and/or Policy Number _____
Effective Date _____
Insurance Company Phone Number _____

COVERAGE DESIRED

Check only employer-sponsored benefits for your employee classification. NOTIFY EMPLOYER WITHIN 31 DAYS OF ANY CHANGE (marriage, first birth, divorce, etc.).

MEDICAL

Underwritten by Educators Health Plans, Life, Accident, and Health

1. PLAN SELECTION

❑ Care Plus Option 1 2 3 4 (Circle one)
❑ Other:_____

2. COVERGE CLASSIFICATION

❑ Employee only
❑ Employee plus one dependent
❑ Employee plus two or more dependents

DENTAL

Underwritten by Educators Health Plans, Life, Accident, and Health

1. PLAN SELECTION

❑ Advantage Co-Pay
❑ Advantage Plus Indemnity
❑ Advantage Plus PPO
❑ Choice Indemnity
❑ Choice PPO
❑ Premier Co-Pay
❑ Premier Indemnity
❑ Premier PPO

❑ **VALUE DISCOUNT DENTAL PROGRAM**
This is discount program, not an insurance policy.
Operated by Educators Mutual Insurance Association

2. COVERGE CLASSIFICATION

❑ Employee only
❑ Employee plus one dependent
❑ Employee plus two or more dependents

VISION

Underwritten by Educators Health Plans, Life, Accident, and Health

1. PLAN SELECTION

❑ VSP ❑ VSP Plus Plan ID#: _____

2. COVERGE CLASSIFICATION

❑ Employee only
❑ Employee plus one dependent
❑ Employee plus two or more dependents

❑ LIFE

Underwritten by Cigna

❑ Employee only
❑ Employee plus one dependent
❑ Employee plus two or more dependents

❑ SHORT-TERM DISABILITY (Employee Only)

Underwritten by Cigna

❑ LONG-TERM DISABILITY (Employee Only)

Underwritten by Cigna

❑ HEALTH SAVINGS ACCOUNT (Employee Only)

☐ New Enrollment ☐ Special Enrollment ☐ Name/Address Change ☐ Beneficiary Change
☐ Change of Coverage ☐ Add Family Member ☐ Cancellation ☐ Delete Family Member
☐ Other: _____ Requested effective date of change: _____

Please read, fill out, and sign the reverse side of this form. Your application cannot be processed without your signature.

RELATIONSHIP TO EMPLOYEE	RELATION TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED / DELETED	SEX	BIRTHDATE			SSN	SAME ADDRESS AS EMPLOYEE?
				MO	DAY	YEAR		
CODE KEY: **I:** Self **S:** Spouse **N:** Natural Child **SC:** Step Child **A:** Adopted **O:** Other (Describe)	**I**	1. Employee						YES
		2.						
		3.						
		4.						
		5.						
		6.						
		7.						
		8.						

ANY MATTER IN DISPUTE BETWEEN YOU AND EMI HEALTH MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM EMI HEALTH. EMI HEALTH SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING,BUT NOT LIMITED TO ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND EMI HEALTH. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

ELECTION TO PARTICIPATE - The policy provides limited benefits. Review your policy/certificate carefully.

I hereby apply for coverage to which I may be entitled or to which I may become entitled under the terms of agreements, including binding arbitration provisions, in the policies issued by Educators Mutual Insurance Association and its subsidiaries (EMI Health) and/or other underwriting companies. I accept the terms of group agreement between my employer and the plans and appoint my employer to act as agent on my behalf. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this coverage. The proposed coverage shall not take effect until this application has been accepted by EMI Health and the other underwriting companies, as applicable, and shall become effective only in accordance with the provisions of such agreements or group policies. I understand that I am not entitled to change my coverage elections during the plan year, unless I experience a special enrollment situation (i.e., marriage, divorce, birth, death, adoption, placement for adoption, or loss of other insurance coverage). I also understand that if I experience such a qualifying event, I may elect to terminate coverage for myself and/or my dependents by providing written notice to my employer within 31 days of the qualifying event. I authorize EMI Health to share PHI concerning me and my family, including adult dependents, with any health care provider or HSA administrator providing benefits. I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signature of Applicant _____ Application Date _____ Enrollment Date _____ Approved By _____

WAIVER OF GROUP COVERAGE

I choose not to participate in the medical insurance benefits that have been offered and hereby waive such coverage. I understand that I may later apply for these benefits if i experience a special enrollment situation (i.e., marriage, divorce, birth, death, adoption, placement for adoption, or loss of other insurance coverage), or during my employer's next open enrollment period.

☐ MEDICAL INSURANCE ☐ DENTAL INSURANCE ☐ VISION INSURANCE ☐ SHORT TERM DISABILITY INSURANCE ☐ LONG TERM DISABILITY INSURANCE ☐ LIFE INSURANCE ☐ HEALTH SAVINGS ACCOUNT

I am waiving this group coverage because I have other coverage: ❑ Yes ❑ No

Signature of Applicant for Waiver Only _____ Date _____