EMI TeleMed™

EMPLOYEE APPLICATION

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EMPLOYER			JOB TITLE			DATE OF EMPLOYMENT
LAST NAME	FIRST NAME	INITIAL	SEX	SOCIAL SECURITY NUMBER		DATE OF BIRTH
ADDRESS / STREET NUMBER			CITY & STATE			ZIP CODE
E-MAIL ADDRESS		HOME PHONE		BUSINESS PHONE		AGENT NAME (if applicable)

COVERED DEPENDENT'S NAMES	SEX	D.O.B.	SOCIAL SECURITY #	COVERED DEPENDENT'S NAMES	SEX	D.O.B.	SOCIAL SECURITY #

ELECTION TO ELECTION TO PARTICIPATE – BY SIGNING BELOW, I ELECT TO PARTICIPATE IN THE EMI TELEMED PROGRAM TO WHICH I AM ENTITLED. I ACCEPT THE TERMS OF THE GROUP AGREEMENT BETWEEN MY EMPLOYER AND EMI HEALTH AND APPOINT MY EMPLOYER TO ACT AS AGENT IN MY BEHALF. I AUTHORIZE THE DEDUCTION FROM MY EARNINGS OF ANY CONTRIBUTION I AM REQUIRED TO MAKE TOWARD THE COST OF THIS PROGRAM. THE PROPOSED PARTICIPATION SHALL NOT TAKE EFFECT UNTIL THIS APPLICATION HAS BEEN ACCEPTED BY EMI HEALTH AND AMERIDOC, AS APPLICABLE, AND SHALL BECOME EFFECTIVE ONLY IN ACCORDANCE WITH THE PROVISIONS OF SUCH AGREEMENTS.

SIGNATURE_____ DATE _____

For EMI Health's Use Only

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Approved by Date