



EMPLOYEE APPLICATION

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

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 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

Approved by _____

Date _____