EMI HEALTH ARIZONA MINI COBRA ALTERNATIVE COVERAGE

5101 South Commerce Dr, Murray, UT 84107-5298 • 801-262-7475 • 800-662-5851 • www.emihealth.com

Plans underwritten or provided by Educators Mutual Insurance Association of Utah • Educators Health Care, Inc.
Educators Health Plans Health, Inc. • Educators Health Plans Life, Accident, and Health, Inc.

To elect continuation coverage, complete this Election Form and return it to us. Under Arizona Revised Statues Title 20-2330, you have 30 days after the date of this notice to decide whether you want to elect continuation coverage.

Applicant's Last Name	First	Middle	Sex	Birth Date	Social Security Number

Street Address	City	State	Zip	PO Box	Telephone Number

NOTIFICATION OF RIGHTS UNDER ARIZONA REVISED STATUES TITLE 20-2330

I hereby certify that I have been notified of my rights under the Arizona Code. I understand that under the Code, I am entitled to be provided with the type of coverage under the plan identical to the coverage provided to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred for up to six months. I further understand that I am required to pay the premium, which may not exceed 102 percent of the applicable premium, for any period of continuation coverage.

The "Qualifying Event" is:

- ☐ Termination of employment (for other than gross misconduct).
- ☐ Work hours reduced below eligibility requirements.
- ☐ Sabbatical, disability, or any leave of absence.
- ☐ Dependent coverage terminated due to death of employee.
- ☐ Divorce or legal separation from employee.
- ☐ A dependent child ceases to be a dependent under the generally applicable requirements of the plan.

Date of qualifying event causing termination of group health care plan: _____
Name of previous employer (district or institution): _____
Name and social security number of previous Educators contract holder:
Name _____ SSN _____

Coverage desired (Please check only employer-sponsored benefits.): ☐ Medical ☐ Dental ☐ Vision

OTHER INSURANCE INFORMATION (THIS SECTION MUST BE COMPLETED)

Do you, your spouse, or dependents have other medical coverage (including Medicare)? ☐ Yes ☐ No
If so, what type of coverage? ☐ Medicare Part A ☐ Medicare Part B ☐ Other Medical
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 _____

RELATIONSHIP TO EMPLOYEE	RELATION TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED	SEX	BIRTHDATE MO	BIRTHDATE DAY	BIRTHDATE YR	SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
CODE KEY: **I:** Self **S:** Spouse **N:** Natural Child **SC:** Step Child **O:** Other (Describe)	I	1. Employee						yes
		2.						
		3.						
		4.						
		5.						
		6.						
		7.						

Continued on reverse →

ELECTION TO PARTICIPATE

I recognize that this offer is independent of any other offer to continue insurance as may be required by the law of any state that applies to this coverage. I certify that I am not presently, nor will I, to the best of my knowledge, be covered under another group health plan within 31 days of this date. I understand that this coverage will terminate on the date that I become covered by other group insurance coverage due to employment, remarriage, or at the expiration of my maximum continuation period. I understand that failure to pay the monthly premium will result in cancellation of the insurance. I further understand that my failure to return this form in a timely manner constitutes waiver of my rights of continuation under* Arizona *Mini COBRA. I authorize Educators Mutual Insurance Association and/or its subsidiary companies to share medical information concerning me or my family with any health care provider providing health benefits within the scope of the group contract. 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.

_____ _____

Applicant's Signature *Date*