



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: <input type="checkbox"/> ACTIVE EMPLOYEE <input type="checkbox"/> RETIRED (RETIREMENT DATE / /) <input type="checkbox"/> 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 Care
 852 East Arrowhead Lane, Murray, UT 84107

1. PLAN SELECTION

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

2. COVERAGE CLASSIFICATION

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

DENTAL

1. PLAN SELECTION

EHC DENTAL

Underwritten by Educators Health Care
 852 East Arrowhead Lane, Murray, UT 84107
 Premier EPO Premier Access
 Advantage EPO Advantage PPO

EMIA DENTAL

Underwritten by Educators Mutual Insurance Association
 Premier Indemnity Premier PPO Choice

VALUE DISCOUNT DENTAL PROGRAM

This is discount program, not an insurance policy.
 Operated by Educators Mutual Insurance Association

2. COVERAGE CLASSIFICATION

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

VISION

1. PLAN SELECTION

EMI Vision
 Underwritten by Educators Mutual Insurance Association
 Opticare Vision
 Underwritten by Opticare of Utah

2. COVERAGE CLASSIFICATION

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

LIFE

Underwritten by Life Insurance Co. of North America - CIGNA
 Employee only
 Employee plus one dependent
 Employee plus two or more dependents

SHORT-TERM DISABILITY (Employee Only)

Underwritten by Life Insurance Co. of North America - CIGNA

LONG-TERM DISABILITY (Employee Only)

Underwritten by Life Insurance Co. of North America - CIGNA

HEALTH SAVINGS ACCOUNT (Employee Only)

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Special Enrollment	<input type="checkbox"/> Name/Address Change	<input type="checkbox"/> Beneficiary Change
<input type="checkbox"/> Change of Coverage	<input type="checkbox"/> Add Family Member	<input type="checkbox"/> Cancellation	<input type="checkbox"/> Delete Family Member
<input type="checkbox"/> 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			SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
				MO	DAY	YR		
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.						

Utah insurance regulations require that we notify you of the following information regarding arbitration.

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.

WAIVER OF GROUP COVERAGE

I choose not to participate in the following group 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, loss of other insurance coverage, or approval to receive a Premium Assistance), 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 _____

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 _____