

LAST NAME	FIRST	INITIAL	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DATE OF EMPLOYMENT
ADDRESS/STREET NO.			CITY & STATE	ZIP CODE	HOME PHONE
					BUSINESS PHONE
SPECIFIC JOB TITLE			E-MAIL ADDRESS		
BENEFICIARY		RELATIONSHIP		CONTINGENT BENEFICIARY	
EMPLOYMENT STATUS: <input type="checkbox"/> ACTIVE EMPLOYEE <input type="checkbox"/> RETIRED (RETIREMENT DATE / /) <input type="checkbox"/> COBRA					
INSURING UNIT: <input type="checkbox"/> UEA <input type="checkbox"/> HIGH DESERT <input type="checkbox"/> BONNEVILLE <input type="checkbox"/> COLOR COUNTRY					
<input type="checkbox"/> JORDAN <input type="checkbox"/> GRANITE <input type="checkbox"/> EASTERN UTAH					
<input type="checkbox"/> WASATCH <input type="checkbox"/> OGDEN/ WEBER <input type="checkbox"/> NORTHERN UTAH					
INSURED LEVEL: <input type="checkbox"/> PROFESSIONAL <input type="checkbox"/> MID MANAGEMENT <input type="checkbox"/> CLASSIFIED <input type="checkbox"/> EXECUTIVE DIRECTOR					

BENEFIT OPTIONS

<p>MEDICAL: P1</p> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one dependent <input type="checkbox"/> Employee plus two or more dependents	<p>DENTAL</p> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one dependent <input type="checkbox"/> Employee plus two or more dependents	<p>VISION</p> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one dependent <input type="checkbox"/> Employee plus two or more dependents
<p>LIFE</p> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one dependent <input type="checkbox"/> Employee plus two or more dependents	<p>SHORT-TERM DISABILITY</p> <input type="checkbox"/> Employee only	<p>LONG-TERM DISABILITY</p> <input type="checkbox"/> Employee only

RELATIONSHIP TO EMPLOYEE	RELATION TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED/DELETED NOTIFY EMPLOYER WITHIN 31 DAYS OF ANY CHANGE (marriage, first birth, divorce, etc.).	WILL INDIVIDUAL BE COVERED FOR:			SEX	BIRTHDATE			SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
			MED	DEN	VIS		MO	DAY	YR		
CODE KEY:											
S: Spouse		1.									
N: Natural Child		2.									
SC: Step Child		3.									
A: Adopted		4.									
O: Other		5.									
		6.									

OTHER INSURANCE INFORMATION

Will you, your spouse, or dependents have other medical or dental coverage (including Medicare) in addition to this Educators coverage?
 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 OR Group/Policy Number _____

Name of Other Insurance Company _____ Insurance Company Phone Number _____

ELECTION TO PARTICIPATE - Please note: Plans may be subject to binding arbitration procedures

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 (EMIA), its subsidiary companies, 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 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 authorize EMIA and or its subsidiary companies to share medical information concerning me and 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.

Signature of Applicant

Application Date

EMPLOYER SIGN OFF SECTION

<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: _____			

Employer Signature

Effective Date

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, or loss of other insurance coverage), or during my employer’s next open enrollment period.

MEDICAL
 DENTAL
 VISION
 LIFE
 LTD
 SHORT-TERM DISABILITY

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

Signature of Applicant for Waiver Only

Date

Additional family members to be covered

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		12.									

