EMI HEALTH Smart Benefits

RETIREE

2017-2018

Alpine Education Association

O ENROLLMENT APPLICATION (Complete entire application.)
O CHANGE FORM (Complete entire application.)

Last Name: ______________ First Name: ______________ Social Security Number: ______________

DOB: __________ Date of Employment: __________ E-Mail: ______________

Address: ______________ City: __________ State: ___ Zip: ______ Phone: __________

Work Location: ______________

EMPLOYMENT STATUS: O ACTIVE EMPLOYEE O RETIRED (RETIREMENT DATE / /) LJ COBRA

DENTAL BENEFIT OPTIONS:

D5 – Choice Plan PPO	D2 – Advantage Plan	D3 – Premiere Plan PPO
O Single - $33.40	O Single - $23.30	O Single - $17.10
O Two Party - $76.70	O Two Party - $54.10	O Two Party - $34.40
O Family - $132.70	O Family - $84.40	O Family - $56.90

Employee SOCIAL SECURITY:

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

OTHER INSURANCE INFORMATION

Will you, your spouse, or dependents have other dental coverage in addition to this EMI Health coverage?

O Yes O No

If so, what is the coverage classification? O Single O Couple O 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 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 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

EMPLOYER SIGN OFF SECTION

O New Enrollment
O Change of Coverage
O Other:
O Special Enrollment
O Add Family Member
O Name/Address Change
O Beneficiary Change
O Cancelation
O Delete Family Member

Employer Signature ______________ Effective Date ______________

Return To: ALPINE UNISERV / AEA, 557 W. Center Street, Pl. Grove, UT 84062 **2017-2018**

FAX : 801-224-6137 Voice: (801) 224-2055 x2 E-mail: annie@alpineuniserv.org

PLEASE SEE REVERSE SIDE FOR waiver of group coverage!

WAIVER OF GROUP COVERAGE

I choose not to participate Jn 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.

○ DENTAL

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

RELATIONSHIP TO EMPLOYEE CODE KEY:	RELATION TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED/DELETED NOTIFY EMPLOYER WITHIN 31 DAYS OF ANY CHANGE (marriage, first birth, divorce, etc.),	SEX	BIRTHDATE MO	DAY	YR	SOCIAL SECURITY NUMBER	SAME ADDRESS, EMPLOYEE
S: Spouse		7.						
B: Biological Child		8.						
SC: Step Child		9.						
A: Adopted		10,						
O: Other		11.						
		12,						

RETURN TO:

Alpine Education Association
Annie Council
557 West Center Street
Pleasant Grove, UT 84062

PAYMENT OPTIONS (SELECT ONE)

○ CHECKING ACCOUNT, I hereby authorize EMI Health to withdraw my monthly payment from my checking account on the business day coinciding with or following the 15th day of each month for the following month's coverage. This authority is to remain in effect until EMI Health has received written notification from me 30 days prior to the next scheduled payment, or until I receive written notification of termination from EMI Health. Failed withdrawals are subject to an additional $10.00 fee

FINANCIAL INSTITUTION ______________________ ACCOUNT NUMBER ______________________

Signature: ______________________________________ Date: ______________

Please include a voided check

○ STATE RETIREMENT, I hereby authorize EMI Health to deduct my monthly remium from my UTAH STATE RETIREME CHECK.