

**RETIREE FORM**

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

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 SS#: \_\_\_\_\_ Date of Employment: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Work Location: \_\_\_\_\_

DENTAL BENEFIT OPTIONS:

**D5 – Choice Plan PPO**

- Single - \$33.40  
 Two Party - \$76.70  
 Family - \$132.70

**D2 – Advantage Plan**

- Single - \$23.30  
 Two Party - \$54.10  
 Family - \$84.40

**D3 – Premiere Plan PPO**

- Single - \$17.10  
 Two Party - \$34.40  
 Family - \$56.90

Employee SOCIAL SECURITY: \_\_\_\_\_

RELATIONSHIP TO EMPLOYEE <b>CODE KEY:</b>	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	BIRTH DATE			SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
				MO	DAY	YR		
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?

- Yes  No

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 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: \_\_\_\_\_

<b>EMPLOYER SIGN OFF SECTION</b>		
<input type="radio"/> New Enrollment	<input type="radio"/> Special Enrollment	<input type="radio"/> Name/Address Change <input type="radio"/> Beneficiary Change
<input type="radio"/> Change of Coverage	<input type="radio"/> Add Family Member	<input type="radio"/> Cancellation <input type="radio"/> Delete Family Member
<input type="radio"/> Other:		
Employer Signature _____	Effective Date _____	

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

**2020-2021**

**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 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.

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**

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				MO	DAY	YR		
<b>CODE KEY:</b>								
S: Spouse		7.						
B: Biological Child		8.						
SC: Step Child		9.						
A: Adopted		10.						
O: Other		11.						
		12.						

**STATE RETIREMENT, I hereby authorize EMI Health to deduct my monthly premium from my UTAH STATE RETIREMENT CHECK.**

**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 15<sup>th</sup> 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 #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**RETURN TO: ALPINE EDUCATION ASSOCIATION, ANNIE COUNCIL, 557 West Center Street, Pl. Grove, UT 84062**