

852 East Arrowhead Lane • Murray, Utah 84107-5298 • 262-7476

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
ADDRESS/STREET NO.		CITY & STATE	ZIP CODE	HOME PHONE	BUSINESS PHONE
BENEFICIARY		RELATIONSHIP	CONTINGENT BENEFICIARY		RELATIONSHIP

OTHER INSURANCE AND EMPLOYMENT INFORMATION (MUST BE COMPLETED IF YOU ANSWER YES)

Do you, your spouse or dependent have other medical insurance? Yes No Effective Date _____

Do you, your spouse or dependent have other dental insurance? Yes No Effective Date _____

Single Coverage Couple Coverage Family Coverage Cancellation Date _____

Name of Other Insured _____ Social Security Number _____

Name of Other Employer _____ Telephone Number _____

Name of Other Insurance Company _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

Group Number and Policy 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.).

1. GROUP MEDICAL COVERAGE (CHECK ONE)

- Educators Care Plus (Indicate physician from list available at personnel department.)
- Educators Health Choice (Indicate physician from list available at personnel department.)
- Educators Select Care
- Educators Advantage Plan

2. EMPLOYEE CLASSIFICATION (CHECK ONE)

- Employee only: NO dual Educators coverage
- Employee only: WITH dual Educators coverage
- Employee plus one dependent
- Employee plus two or more dependents

3. LIFE INSURANCE

- Employee only
- Employee with spouse and/or dependent children

4. LONG-TERM DISABILITY

- Employee only

5. SHORT-TERM DISABILITY

- Employee only

6. DENTAL

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

7. VISION

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

PERSONNEL OFFICE USE

- New Enrollment
- Add Dependent
- Cancellation
- Delete Dependent
- Change of Coverage
- Beneficiary Change
- Special Enrollment
- Current Salary \$ _____
- Other: _____

WAIVER OF GROUP INSURANCE

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 INSURANCE LIFE INSURANCE / EMPLOYEE LIFE INSURANCE / DEPENDENTS LONG-TERM DISABILITY SHORT-TERM DISABILITY DENTAL

Signature of Applicant for Waiver Only _____

Date _____

RELATIONSHIP TO EMPLOYEE	RELATION TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED	SEX	BIRTHDATE			SOCIAL SECURITY NUMBER	PRIMARY CARE PHYSICIAN (PCP)	
				MO	DAY	YR		Provider #	Provider Name
CODE KEY: I: Self S: Spouse N: Natural Child SC: Step Child A: Adopted O: Other (Describe)	I	1. Employee							
		2.							
		3.							
		4.							
		5.							
		6.							
		7.							

Please see reverse side for information regarding arbitration.

ELECTION TO PARTICIPATE

I hereby apply for coverage to which I may be entitled or to which I may become entitled under the terms of the agreement including mandatory binding arbitration provisions in the policies issued by Educators Mutual Insurance Association and/or its subsidiary companies. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this coverage. I agree that the proposed coverage shall not take effect until this application has been accepted by Educators Mutual Insurance Association and/or its subsidiary companies as applicable and shall become effective only in accordance with the provisions of such agreements, group policy or policies. 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.

Signature of Applicant
EMIA.EN.GEN.0399.1399

Date

Effective Date

Approved By

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

ANY MATTER IN DISPUTE BETWEEN THE INSURED AND THE COMPANY MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION, A COPY OF WHICH IS AVAILABLE FROM THE COMPANY. ALL PARTIES ARE BOUND BY THE DECISION OF THE ARBITRATION COMMITTEE, WHICH IS FINAL. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES IF ALLOWED BY STATE LAW AND MAY BE ENTERED AS A JUDGEMENT IN ANY COURT OF PROPER JURISDICTION.
