

- ENROLLMENT APPLICATION** (Complete entire application.)  
 **CHANGE FORM** (Complete shaded boxes and all changed information.)

Educators Mutual Insurance Association of Utah • 852 East Arrowhead Lane • Murray, Utah 84107-5298 • 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	
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 Plans Health

**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

**2. Coverage Classification**

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

**VISION**

Underwritten by Educators Health Plans Life, Accident, and Health

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

**DENTAL**

**1. Plan Selection**

- EHPH Dental**  
Underwritten by Educators Health Plans Health  
 Premier EPO     Premier Access  
 Advantage EPO     Advantage PPO

**EHPL DENTAL**

Underwritten by Educators Health Plans Life, Accident, and Health  
 Premier Indemnity     Premier PPO

**VALUE DISCOUNT DENTAL PROGRAM**

**This is discount program, not an insurance policy.**  
Operated by Educators Health Plans Life, Accident, and Health

**LIFE**

[Underwritten by Prudential Insurance Company of America  
751 Broad Street, Newark, NJ 07102-3777

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

**SHORT-TERM DISABILITY (Employee Only)**

[Underwritten by Life Insurance Company of North America  
1601 Chestnut Street, 2 Liberty, Philadelphia, PA 19192]

**LONG-TERM DISABILITY (Employee Only)**

[Underwritten by Life Insurance Company of North America  
1601 Chestnut Street, 2 Liberty, Philadelphia, PA 19192]

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		
<b>CODE KEY:</b> <b>I:</b> Self <b>S:</b> Spouse <b>N:</b> Natural Child <b>SC:</b> Step Child <b>A:</b> Adopted <b>O:</b> Other (Describe)	I	1. Employee					yes	
		2.						
		3.						
		4.						
		5.						
		6.						
		7.						

- New Enrollment     Special Enrollment     Name/Address Change     Beneficiary Change  
 Change of Coverage     Add Family Member     Cancellation     Delete Family Member  
 Other: \_\_\_\_\_    Requested effective date of change: \_\_\_\_\_

**Please read and sign the reverse side of this form. Your application cannot be processed without your signature.**

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

**ANY MATTER IN DISPUTE BETWEEN YOU AND EDUCATORS 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 EDUCATORS. EDUCATORS 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 EDUCATORS. 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 INS.     LONG-TERM DISABILITY INS.     LIFE INSURANCE

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

\_\_\_\_\_  
Signature of Applicant for Waiver Only

\_\_\_\_\_  
Date

**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 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 the group agreement between my employer and the plans and appoint my employer to act as agent in 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 or 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

\_\_\_\_\_  
Enrollment Date

\_\_\_\_\_  
Approved By