EMI HEALTH Smart Benefits

2018-2019

Alpine Education Association

RETIREE FORM

O ENROLLMENT APPLICATION (Complete entire application.)

O 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: _____

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

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 **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	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?

O Yes O 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

EMPLOYER SIGN OFF SECTION

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

Employer Signature Effective Date

Return To: ALPINE UNISERV / AEA, 557 W. Center Street, Pl. Grove, UT 84062 **2018-2019**

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	BIRTH DATE			SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
				MO	DAY	YR		
S: Spouse		7.						
B: Biological Child		8.						
SC: Step Child		9.						
A: Adopted		10,						
O: Other		11.						
		12,						

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 #: _____

Signature:_____ Date: _____

PLEASE INCLUDE A VOIDED CHECK

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

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