

Alpine Uniserv

2023-2024

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

Complete application to enroll in EMI Health or TDA Dental

LAST NAME	FIRST	INITIAL	GENDER	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DATE OF EMPLOYMENT
ADDRESS/STREET NO.			CITY & STATE	ZIP CODE	HOME PHONE	BUSINESS PHONE
SPECIFIC JOB TITLE				E-MAIL ADDRESS		
EMPLOYMENT STATUS: <input type="checkbox"/> ACTIVE EMPLOYEE <input type="checkbox"/> RETIRED (RETIREMENT DATE / /) <input type="checkbox"/> COBRA						

BENEFIT OPTIONS

Dental Benefit Options

- | | | | |
|---|--|--|---|
| Peak Care Plus, DHMO
<input type="checkbox"/> Single \$14.03
<input type="checkbox"/> Two-Party \$29.12
<input type="checkbox"/> Family \$45.67 | Elite Choice
<input type="checkbox"/> Single \$29.01
<input type="checkbox"/> Two-Party \$60.42
<input type="checkbox"/> Family \$99.77 | TDA PPO/MAC
<input type="checkbox"/> Single \$36.87
<input type="checkbox"/> Two-Party \$83.12
<input type="checkbox"/> Family \$140.31 | TDA Companion
<input type="checkbox"/> Single \$40.72
<input type="checkbox"/> Two-Party \$87.52
<input type="checkbox"/> Family \$144.32 |
| *Dental Office Selected* # | | | |
| Choice PPO D5
<input type="checkbox"/> Single \$35.70
<input type="checkbox"/> Two-Party \$81.90
<input type="checkbox"/> Family \$141.80 | Advantage Co-Pay D2
<input type="checkbox"/> Single \$24.90
<input type="checkbox"/> Two-Party \$57.80
<input type="checkbox"/> Family \$90.20 | Premier Plan PPO D3
<input type="checkbox"/> Single \$18.20
<input type="checkbox"/> Two-Party \$36.80
<input type="checkbox"/> Family \$60.70 | |

RELATIONSHIP TO EMPLOYEE CODE KEY:	RELATIONSHIP TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED/DELETED DAYS OF ANY CHANGE	NOTIFY EMPLOYER WITHIN 31 (marriage, birth, divorce, etc.).	SEX	BIRTHDATE			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.								
	7.								
	8.								

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?

Name of Insured Single Couple Family
 Name of Other Insurance Company Insured's Social Security Number OR Group/Policy Number
 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 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/HRA 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

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> New Enrollment | <input type="checkbox"/> Special Enrollment | <input type="checkbox"/> Name/Address Change | <input type="checkbox"/> Beneficiary Change |
| <input type="checkbox"/> Change of Coverage | <input type="checkbox"/> Add Family Member | <input type="checkbox"/> Cancellation | <input type="checkbox"/> Delete Family Member |
| <input type="checkbox"/> Other: _____ | | | |

Employer Signature _____

Effective Date _____

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 _____

Effective Date _____

2023-2024

Return To: Alpine Education Association/Alpine Uniserv
 557 W. Center St. Pleasant Grove, UT 84062
 Email: annie@alpineuniserv.org
 Phone: 801-224-2055 Ext. 2

EMI HEALTH™

TDA

AN EMI HEALTH COMPANY

*This form will supersede any other form on file