

# UTAH VALLEY UNIVERSITY

Educators Mutual Insurance Association of Utah • 852 East Arrowhead Lane • Murray, Utah 84107-5298 • 262-7475

SPECIFIC JOB TITLE			DATE OF EMPLOYMENT	POLICY NUMBER (FOR OFFICE USE ONLY)	
LAST NAME	FIRST	INITIAL	EMPLOYEE SOCIAL SECURITY NO.	EMPLOYEE DATE OF BIRTH	E-MAIL ADDRESS
ADDRESS/STREET NO.		CITY & STATE	ZIP CODE	HOME PHONE	BUSINESS PHONE
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**

<p><b>GROUP MEDICAL COVERAGE</b></p> <p><input type="checkbox"/> Employee only</p> <p><input type="checkbox"/> Employee + one dependent</p> <p><input type="checkbox"/> Family</p> <p><b>DENTAL - PREMIER INDEMNITY</b></p> <p><input type="checkbox"/> Employee only</p> <p><input type="checkbox"/> Employee + one dependent</p> <p><input type="checkbox"/> Family</p>	<p><b>LIFE</b></p> <p>Underwritten by Minnesota Life Insurance Company a Securian Co</p> <p><input type="checkbox"/> Employee only</p> <p><input type="checkbox"/> Employee with spouse and/or dependent children (dependent premium paid by employee)</p> <p><b>LONG-TERM DISABILITY</b></p> <p>Underwritten by Life Insurance Company of North America a CIGNA Company</p> <p><input type="checkbox"/> Employee only</p>	<p><b>VISION</b></p> <p><input type="checkbox"/> Employee only</p> <p><input type="checkbox"/> Employee + one dep.</p> <p><input type="checkbox"/> Family</p>
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**Please see reverse side for waiver of group coverage.**

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.						

**Please note: Plans may be subject to binding arbitration procedures.**

**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 \_\_\_\_\_

**WAIVER OF GROUP COVERAGE**

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

DENTAL INSURANCE

VISION INSURANCE

LONG-TERM DISABILITY INS.

LIFE INSURANCE

I am waiving this group coverage because I have other coverage:

Yes

No

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Signature of Applicant for Waiver Only

Date