

UTAH VALLEY STATE COLLEGE

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

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	
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

GROUP MEDICAL COVERAGE

- Employee only
- Employee plus one dependent
- Employee plus two or more dep.

DENTAL

- Employee only
- Employee plus one dependent
- Employee plus two or more dep.

LIFE

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

- Employee only
- Employee with spouse and/or dependent children (dependent premium paid by employee)

VISION

- Employee only
- Employee plus one dep.
- Employee plus two or more dep.

LONG-TERM DISABILITY

Underwritten by Hartford Life and Accident Insurance Company
PO Box 2999 Hartford, CT 06104-2999

- Employee only

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		
CODE KEY: I: Self S: Spouse N: Natural Child SC: Step Child A: Adopted O: 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

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

DENTAL INSURANCE

VISION INSURANCE

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