



- ENROLLMENT APPLICATION (complete entire application)
 CHANGE FORM (complete entire application)

For Office Use Only

EFFECTIVE DATE

2019 USEA Voluntary Dental / Vision / TeleMed Enrollment Application

LAST NAME	FIRST	INITIAL	SEX	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS/STREET NO.			CITY & STATE		ZIP CODE
HOME PHONE	BUSINESS PHONE	E-MAIL ADDRESS		SCHOOL DISTRICT	

BENEFIT OPTIONS - Monthly Rates

DENTAL: Choice PPO

- Employee \$41.40
 Two Party \$80.80
 Family \$125.80

DENTAL: Advantage Co-Pay

- Employee \$21.50
 Two Party \$44.30
 Family \$74.00

DENTAL: Value

- Employee **FREE**
 Two Party \$3.00
 Family \$5.00

VSP VISION - 10-130P

- Employee \$9.20
 Two Party \$17.90
 Family \$28.50

TELEMED

- \$5.50

Basic Life Employee \$5,000

- Employee \$3.00

Basic Life for Spouse/Dependents \$2,200

- Spouse / Dependents \$1.00

RELATIONSHIP TO EMPLOYEE	RELATION TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED/DELETED NOTIFY EMPLOYER WITHIN 31 DAYS OF ANY CHANGE (marriage, first birth, divorce, etc.).	WILL INDIVIDUAL BE COVERED FOR:			SEX	BIRTHDATE			SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
			DEN	VIS	TELE		MO	DAY	YR		
S: Spouse		1.									
B: Biological Child		2.									
SC: Step Child		3.									
A: Adopted		4.									
O: Other		5.									
		6.									

DO YOU AND/OR ANY DEPENDENTS TO BE COVERED ON THIS PLAN HAVE OTHER DENTAL INSURANCE?

- YES NO

IF YES, WHO IS THE SUBSCRIBER/POLICY HOLDER? _____

OTHER DENTAL INSURANCE COMPANY/CARRIER _____

I wish to enroll in the EMI Health plan(s) checked above. In signing this application, I understand that I am authorizing EMI Health to ACH deduct the monthly premium for the coverage selected.

Furthermore, I understand that I am responsible for the monthly premiums and will notify USEA (exclusively) if there are any changes in my status regarding dental coverage and also agree to remain in the plan for a minimum of one year.

I also 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).

Signature of Applicant _____

Application Date _____

Required Information to Complete Enrollment

Election to participate - by checking here and signing below, I apply for EMI plan(s), to be effective upon acceptance of this application by EMI Health. I hereby authorize EMI Health to withdraw my total monthly payment on or about the 1st day of each month, for that month's access. 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. I understand that I may not terminate my access mid-month or receive refunds for any payments made whether or not I use the services. Failed withdrawals will be subject to an additional fee or termination of coverage.

CHECKING ACCOUNT

Financial Institution Name _____
 Account Number _____
 Routing number _____
 (9 digit bank number at bottom of a check)

CREDIT CARD

Card Number _____
 Expiration Date _____
 Name Displayed on Card _____
 Address _____
 City/State/Zip _____

Signature _____

Date _____

The proposed coverage shall not take effect until this application has been accepted by EMI Health. Coverage under the Policy begins on the applicable effective date as stated on the face page of the Policy, which will be delivered to the Subscriber through the US Postal Service.



Utah
School
Employees
Association

Please mail, email or fax this application to
 USEA - 864 E. Arrowhead Lane, Murray, UT 84107
 email: membership@useautah.org
 fax: 801-269-9324

Questions
 Call 801-269-9320