EMI HEALTH

☐ **ENROLLMENT APPLICATION** (complete entire application)
☐ **CHANGE FORM** (complete entire application)

For Office Use Only
EFFECTIVE DATE

2021 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 $42.60
☐ Two Party $83.20
☐ Family $129.50

DENTAL: Advantage Co-Pay
☐ Employee $22.10
☐ Two Party $45.60
☐ Family $76.20

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
☐ $6.00

Basic Life Employee $5,000
☐ Employee $3.00

Basic Life for Spouse/Dependents $2,200
☐ Spouse / Dependents $1.00

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.).	WILL INDIVIDUAL BE COVERED FOR: DEN	VIS	TELE	SEX	BIRTHDATE MO	DAY	YR	SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
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 authoriz 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 Membership- PO Boc 241, Roy, UT 84067
email: membership@useautah.org
fax: 801-269-9324

Questions
Call 801-269-9320