EMI HEALTH™

4752 - University of Utah Graduate Students

5101 South Commerce Drive
Murray, Utah 84107

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

For Office Use Only

EFFECTIVE DATE

1. DEPARTMENT COMPLETE (Department premark payment box below)

Location Number _____

☐ Dependent Coverage Paid by Student (Student Complete Sections 2, 3 & 4)
☐ Dependent Coverage Paid by Department (Student Complete Sections 2 & 3)

2. STUDENT INFORMATION

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

3. BENEFIT OPTIONS - Monthly Rates

DENTAL: Advantage Co-Pay

☐ Student	$9.90	(Paid by Department)
☐ + Spouse	+ $10.80	
☐ + Child(ren)	+ $12.30	
☐ + Family	+ $23.60	

VISION: VSP 10-130

☐ Student	$4.00	(Paid by Department)
☐ + Spouse	+ $3.80	
☐ + Child(ren)	+ $8.40	
☐ + Family	+ $8.40	

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

DO YOU AND/OR ANY DEPENDENTS TO BE COVERED ON THIS PLAN HAVE OTHER DENTAL OR VISION INSURANCE? ☐ YES ☐ NO

IF YES, WHO IS THE SUBSCRIBER/POLICY HOLDER? _____ OTHER DENTAL INSURANCE COMPANY/CARRIER _____

4. Payment Options

Complete this section only if student is responsible for dependent coverage payment.

By checking here and signing below, 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 _____

Please read, fill out, and sign the reverse side of this form. Your application cannot be processed without your signature.

ANY MATTER IN DISPUTE BETWEEN YOU AND EMI HEALTH MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM EMI HEALTH.
EMI HEALTH SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES.
OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES.
ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND EMI HEALTH. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

ELECTION TO PARTICIPATE - The policy provides dental and/or vision benefits only. Review your policy/certificate carefully.

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 the policyholder and the plans and appoint the policyholder to act as agent on my behalf. The proposed coverage shall not take effect until this application has been accepted by EMI Health and 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 such a qualifying event, I may elect to terminate coverage for myself and/or my dependents by providing written notice to the policyholder 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 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 | Enrollment Date | Approved By

WAIVER OF GROUP COVERAGE

I choose not to participate in the insurance 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 the Policyholder's next open enrollment period.

☐ **DENTAL INSURANCE** ☐ **VISION INSURANCE**

I am waiving this group coverage because I have other coverage: ☐ Yes ☐ No

Signature of Applicant for Waiver Only | Date

Send Completed Application to: **enrollment@emihealth.com**

Phone: 800-662-5851
Fax: 801-269-9734