EMI TeleMed™

EMPLOYEE APPLICATION

5101 S Commerce Drive • Murray, Utah 84107 • 801-270-2967 • www.emihealth.com

EMPLOYER	JOB TITLE				DATE OF EMPLOYMENT
LAST NAME	FIRST NAME	INITIAL	SEX	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS / STREET NUMBER	CITY & STATE				ZIP CODE
E-MAIL ADDRESS	HOME PHONE	BUSINESS PHONE			AGENT NAME (if applicable)

COVERED DEPENDENT'S NAMES	SEX	D.O.B.	SOCIAL SECURITY #	COVERED DEPENDENT'S NAMES	SEX	D.O.B.	SOCIAL SECURITY #

ELECTION TO ELECTION TO PARTICIPATE – BY SIGNING BELOW, I ELECT TO PARTICIPATE IN THE EMI TELEMED PROGRAM TO WHICH I AM ENTITLED. I ACCEPT THE TERMS OF THE GROUP AGREEMENT BETWEEN MY EMPLOYER AND EMI HEALTH 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 PROGRAM. THE PROPOSED PARTICIPATION SHALL NOT TAKE EFFECT UNTIL THIS APPLICATION HAS BEEN ACCEPTED BY EMI HEALTH AND AMERIDOC, AS APPLICABLE, AND SHALL BECOME EFFECTIVE ONLY IN ACCORDANCE WITH THE PROVISIONS OF SUCH AGREEMENTS.

SIGNATURE_____ DATE _____

For EMI Health's Use Only

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Approved by Date