EMI TeleMed™

GROUP APPLICATION

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

EMPLOYER INFORMATION

EMPLOYER'S NAME		TAX IDENTIFICATION NUMBER (TIN)	SIC CODE AND/OR NATURE OF BUSINESS
ADDRESS		CITY & STATE	ZIP CODE
PHONE	FAX	E-MAIL	
BILLING ADDRESS		CITY & STATE	ZIP CODE
BILLING E-MAIL ADDRESS		PREFERRED BILLING METHOD ◯ ELECTRONIC ◯ PAPER	NUMBER OF EMPLOYEES ENROLLING
ADMINISTRATIVE CONTACT - NAME AND TITLE			
REQUESTED EFFECTIVE DATE			

COBRA ADMINISTRATION

DO YOU HAVE 20 OR MORE W2 EMPLOYEES (INCLUDING PART-TIME?) ◯ Yes ◯ No	IF YES, WOULD YOU LIKE EMI HEALTH TO ADMINISTER COBRA? ◯ Yes ◯ No; Administrator _____	IF NO, WOULD YOU LIKE EMI HEALTH TO ADMINISTER QR?RC AMLR, AMTCP?EC? ◯ Yes ◯ No

***Attach census if EMI Health will be administering COBRA. Option must be made at the time of application; no changes will be allowed after acceptance of application.**

BENEFITS See quote or RFP response for participation requirements.

◯ **$10 Consult fee** ◯ **Other:** _____ ◯ **$30 Consult fee**	◯ **Employer sponsored** ◯ **Voluntary**

ENROLLMENT SUMMARY

# OF ENROLLEES	PEPM	TOTAL ACCESS FEE
	Total First Month (must be included with this application)	

SIGNATURES

By signing below, the authorized person attests that he or she:

- understands that participating providers are not agents, representatives, nor employees of Educators Mutual, nor its affiliates (EMI Health).
- represents that all information on this application and any attachment is correct and complete to the best of his or her knowledge and that the discovery of any intentional material misrepresentation shall result in the termination of the program.
- understands that no agent has the authority to modify or waive any conditions of this application or pprogram, nor to bind EMI Health, by making any promise or representation.
- agrees to maintain and furnish any records necessary for the efficient administration of the program.
- understands that only those employees who meet eligibility requirements may participate in the program and that participation and contribution requirements must be met before this will become effective and that such requirements must be maintained to prevent termination of the agreement.

Authorized Person's Signature _____ Date _____

Printed Name _____ Time _____

Agent Name _____ Agent Phone Number _____

Agency Name _____ Agent E-mail Address _____

For EMI Health's Use Only

Approved by _____ Date _____