



UTAH COMMERCIAL GROUP APPLICATION

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

EMPLOYER INFORMATION

Table with 3 columns: EMPLOYER'S NAME, TAX IDENTIFICATION NUMBER (TIN), SIC CODE AND / OR NATURE OF BUSINESS. Rows include ADDRESS, BILLING ADDRESS, CONTACT INFORMATION, EMPLOYEE COUNT, and ELIGIBILITY CHECKS.

ENROLLMENT SUBMISSION

How do you intend to submit your enrollment?

- Input boxes for Paper Application, Excel Spreadsheet, 834 file, and Employee Navigator with descriptive text.

BENEFITS See quote or RFP response for participation requirements

MEDICAL (Contributory Only)

Employer's contribution for employee, dependent, and number waiving coverage.

Underwritten by Educators Health Plans Life, Accident, & Health

Fully-Insured Care Plus

Administered by Educators Health Plans Life, Accident, & Health

- Modified Care Plus, Self-funded Care Plus

Pool name (if applicable), Plan option #

Do you want to participate in the All Payer Claims Database (APCD)?

- YES, NO

DENTAL

- Voluntary, Contributory

Employer's contribution for employee, dependent, and number waiving coverage.

Underwritten by Educators Health Plans Life, Accident, & Health

- Advantage Co-Pay, Advantage Plus Indemnity, Advantage Plus PPO, Choice PPO, Choice Indemnity, Premier PPO, Premier Co-Pay, Premier Indemnity, Summit PPO, Summit Indemnity, Summit Plus PPO, Summit Plus Indemnity

Administered by Educators Health Plans Life, Accident, & Health

Self-funded

Operated by Educators Health Plans Life, Accident, & Health

Value Discount Program (not an insurance product)

VISION

- Voluntary, Contributory

Employer's contribution for employee, dependent, and number waiving coverage.

VSP, VSP Plus, Plan ID#

ENROLLMENT SUMMARY

PLAN	THREE TIER	FOUR TIER	NUMBER OF ENROLLEES	RATE	TOTAL PREMIUM
	Employee	Employee			
	Two-party	Employee/Spouse			
		Employee/Child(ren)			
	Family	Family			
	Employee	Employee			
	Two-party	Employee/Spouse			
		Employee/Child(ren)			
	Family	Family			
	Employee	Employee			
	Two-party	Employee/Spouse			
		Employee/Child(ren)			
	Family	Family			
	Employee	Employee			
	Two-party	Employee/Spouse			
		Employee/Child(ren)			
	Family	Family			
Premium Subtotal					
Dental Monthly Administrative Fee (\$2.00 per employee, \$20.00 maximum). Waived if ACH.					
Total First Month's Premium (must be included with this application)					

Attach additional enrollment summary sheet if necessary.

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 policy.
- understands that no insurance will become effective until approved by EMI Health.
- understands that no agent has the authority to modify or waive any condition of this application or policy, 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 policy.
- understands that only those employees who meet eligibility requirements are to be covered under the policy and that participation and contribution requirements must be met before this policy will become effective and that such requirements must be maintained while the policy is in force to prevent termination of the policy.
- understands that coverage under the policy can be terminated in accordance with its terms and conditions.

I hereby request insurance for eligible persons based on the information provided on this application and any attachment, and where applicable agree to be bound by the terms and conditions of any trust agreement establishing a trustee as policyholder. I understand that insurance will not go into effect until the the required premium is paid for the benefits selected.

Authorized Person's Signature

Date

Printed Name

Title

Agent Name

Agent Phone Number

Agency Name

Agent E-mail Address