Dental, & Vision Enrollment Form

Please Print Clearly

Employee Information

Worksite Employer	Employee Last Name	First Name	Date of Birth	Social Security Number	Gender

Employee Mailing Address	City	State	Zip	Phone Number

Specific Job Title	Email Address

Employment Status: ☐ Full Time (30 + hours per week) ☐ Part Time (29 or fewer hours per week)

Benefit Options

Dental Election

Check Desired Plan Option
**option only available to Utah Residents*

☐Value *
☐Advantage
☐Choice Indemnity Care
☐Choice Indemnity Plus
☐*I elect to waive coverage*

Check Coverage Level Desired

☐Single
☐Employee + Spouse
☐Employee + Child
☐Family

Vision Election

Check Desired Plan Option

☐VSP 10/100
☐VSP 10/160
☐*I elect to waive coverage*

Check Coverage Level Desired

☐Single
☐Employee + Spouse
☐Employee + Child
☐Family

Dependent Information

Relation to Employee	List All Family Members to be Covered	Will Individual be Covered on:			M/F	DOB			Social Security Number	Different Address?
		Med	Den	Vis		MO	DAY	YR		
	1									
	2									
	3									
	4									
	5									
	6									

Relation to Employee Code Key:

S: Spouse

D: Dependent Child

Other Medical Coverage Information

Will you, your spouse, or dependents have other medical coverage (including Medicare) in addition to this EMI Health coverage? ☐Yes ☐No

If yes, what type of coverage: ☐Medicare Part A ☐Medicare Part B ☐Group Medical ☐Individual Medical ☐High Deductible with HSA

What coverage level: ☐Single ☐Two-Party ☐Family

Name of Insured: _____ Primary Insured's SSN or Policy Number: _____

Name of Other Insurance Carrier: _____ Insurance Company Phone Number: _____

Election To Participate

I understand the information presented to me about the plans and I have made the coverage selections represented on this form. I understand that the coverage shall become effective only in accordance with the provisions of such agreements or group policies. I understand that I must maintain 30 hours per week to remain eligible for these benefits. I authorize A Plus Benefits to make deductions from my earnings for my share of the cost, if any, of the benefits to which I may become entitled. I also understand that coverage may not be changed until Open Enrollment, or within 31 days of special enrollment situation. I understand that if I am waiving coverage for myself or any dependents that I may be eligible to enroll with a special enrollment situation, as long as I request enrollment within 31 days. I authorize EMI Health to share PHI concerning me and my family, including adult dependents, with any health care provider or HSA / HRA administrator providing benefits. I certify that the information I have provided on this form is true and complete, and that any person who includes false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

_____ _____

Applicant Signature Date

Office Use Only

☐ Regular ☐Qualifying Event:	Hire Date:	Effective Date:	Client ID: