

LAST NAME	FIRST	INITIAL	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DATE OF EMPLOYMENT
			- -	/ /	/ /
ADDRESS/STREET NO.		CITY & STATE		ZIP CODE	
				HOME PHONE	
				BUSINESS PHONE	
SPECIFIC JOB TITLE			E-MAIL ADDRESS		
BENEFICIARY		RELATIONSHIP		CONTINGENT BENEFICIARY	
EMPLOYMENT STATUS: <input type="checkbox"/> ACTIVE EMPLOYEE <input type="checkbox"/> RETIRED (RETIREMENT DATE / / ) <input type="checkbox"/> COBRA					

**BENEFIT OPTIONS**

<p><b>GROUP MEDICAL COVERAGE</b></p> <p><input type="checkbox"/> Employee only</p> <p><input type="checkbox"/> Employee plus one dependent</p> <p><input type="checkbox"/> Employee plus two or more dependents</p>	<p><b>DENTAL INSURANCE</b></p> <p><input type="checkbox"/> Employee only</p> <p><input type="checkbox"/> Employee plus one dependent</p> <p><input type="checkbox"/> Employee plus two or more dependents</p>	<p><b>VISION</b></p> <p><input type="checkbox"/> Employee only</p> <p><input type="checkbox"/> Employee plus one dependent</p> <p><input type="checkbox"/> Employee plus two or more dependents</p>
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RELATIONSHIP TO EMPLOYEE	RELATION TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED/DELETED NOTIFY EMPLOYER WITHIN 31 DAYS OF ANY CHANGE (marriage, first birth, divorce, etc.).	WILL INDIVIDUAL BE COVERED FOR:			SEX	BIRTHDATE			SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
			MED	DEN	VIS		MO	DAY	YR		
<b>CODE KEY:</b>											
S: Spouse	1.										
N: Natural Child	2.										
SC: Step Child	3.										
A: Adopted	4.										
O: Other	5.										
	6.										

**OTHER INSURANCE INFORMATION**

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

If so, what type of coverage?  Medicare Part A  Medicare Part B  Other Medical  Dental

If so, what is the coverage classification?  Single  Couple  Family

Name of Insured \_\_\_\_\_ Insured's Social Security Number OR Group/Policy Number \_\_\_\_\_

Name of Other Insurance Company \_\_\_\_\_ Insurance Company Phone Number \_\_\_\_\_

**ELECTION TO PARTICIPATE - Please note: Plans may be subject to binding arbitration procedures**

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 (EMIA), its subsidiary companies, and/or other underwriting companies. I accept the terms of group agreement between my employer and the plans and appoint my employer to act as agent on my behalf. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this coverage. The proposed coverage shall not take effect until this application has been accepted by 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 authorize EMIA and or its subsidiary companies to share medical information concerning me and my family with any health care provider providing health benefits within the scope of the group contract. 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

**EMPLOYER SIGN OFF SECTION**

New Enrollment  Special Enrollment  Name/Address Change  Beneficiary Change  
 Change of Coverage  Add Family Member  Cancellation  Delete Family Member  
 Other: \_\_\_\_\_

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Effective Date

**WAIVER OF GROUP COVERAGE**

I choose not to participate in the following group 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 my employer's next open enrollment period.

MEDICAL INSURANCE

DENTAL INSURANCE

VISION INSURANCE

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

Signature of Applicant for Waiver Only

Date

**Additional family members to be covered**

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<b>N:</b> Natural Child		8.									
<b>SC:</b> Step Child		9.									
<b>A:</b> Adopted		10.									
<b>O:</b> Other		11.									
		12.									