



UEA NEW HIRE BasicMED—A LIMITED BENEFIT PLAN

ENROLLMENT APPLICATION (Please complete the entire application.)

EMI Health • 852 E. Arrowhead Lane • Murray, Utah 84107-5298 • 801-262-7475

EMPLOYER	SPECIFIC JOB TITLE	DATE OF EMPLOYMENT	POLICY NUMBER (FOR OFFICE USE ONLY)	
LAST NAME	FIRST	INITIAL	EMPLOYEE SOCIAL SECURITY NUMBER	EMPLOYEE DATE OF BIRTH
ADDRESS/STREET NO.		CITY & STATE	ZIP CODE	
E-MAIL ADDRESS		HOME PHONE	SCHOOL PHONE	
BENEFICIARY		RELATIONSHIP	CONTINGENT BENEFICIARY	RELATIONSHIP

OTHER INSURANCE INFORMATION (THIS SECTION MUST BE COMPLETED)

Do you, your spouse, or dependents have other medical coverage (including Medicare)? Yes No

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

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

Name of Insured _____

Insured's Social Security Number _____

Name of Other Insurance Company _____

Please provide any of the following information you may have:

Group and/or Policy Number _____

Effective Date _____

Insurance Company Phone Number _____

RELATIONSHIP TO EMPLOYEE	RELATIONSHIP TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED/DELETED	SEX	BIRTHDATE MO DAY YR	SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
CODE KEY: I: Self S: Spouse N: Natural Child SC: Step Child A: Adopted O: Other (Describe)	I	1. EMPLOYEE				YES
		2.				
		3.				
		4.				
		5.				
		6.				
		7.				

PAYMENT OPTIONS (PLEASE SELECT ONE)

CHECKING ACCOUNT. I hereby authorize EMI Health to withdraw my premium payment each month from my checking account. Failed withdrawals are subject to an additional \$10.00 fee.

DEBIT CARD. (If using a debit card, please provide your account number and routing number in this section only.)

Financial Institution _____ Account Number _____

Routing Number _____ Expiration Date _____

Signature _____ Date _____

Include a voided check. No deposit slips please. If using a debit card, this is not required.
Please read and sign the reverse side of this form. Your application cannot be processed without your signature.

CREDIT CARD. I hereby authorize EMI Health to charge my premium payment for the entire plan period to the following credit card.

VISA MasterCard

Account Number _____ Expiration Date _____

Signature _____ Date _____

Please read and sign the reverse side of this form. Your application cannot be processed without your signature.

ELECTION TO PARTICIPATE

I hereby apply for coverage to which I may be entitled or to which I may become entitled under the terms of the agreements, including binding arbitration provisions, in the policies issued by EMI Health, its subsidiary companies, and/or other underwriting companies. I accept the terms of the group agreement between my association and the plans and appoint my employer to act as agent in my behalf. 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 period, 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 EMI Health and/or its subsidiary companies to share medical information concerning me or 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.

By signing below, I also acknowledge that the UEA BasicMED Plan has a \$10,000 per person benefit maximum. Any claims exceeding \$10,000 will be my responsibility.

Signature of Applicant

Application Date

Enrollment Date

*Please return to your local association office or its designee,
or you may fax this completed form to UEA, ATTN: BasicMED at 801-265-2249.*

NOTICE

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least \$750,000.

Your health insurance coverage, offered by Utah Education Association and its affiliates, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of \$10,000 on all covered benefits. In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least \$750,000 this year. That waiver was granted by the U.S. Department of Health and Human Services, based on your health plan’s representation, that providing \$750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact EMI Health at 800-662-5851.