



# UEA NEW HIRE BASICMED—A LIMITED BENEFIT PLAN

## ENROLLMENT APPLICATION (Please complete the entire application.)

Educators Mutual Insurance Association of Utah • 852 East 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	E-MAIL ADDRESS
ADDRESS/STREET NO.			CITY & STATE	ZIP CODE	HOME PHONE	
					BUSINESS 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?
<b>CODE KEY:</b> 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 Educators Mutual 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 Educators Mutual 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 Educators Mutual Insurance Association (EMIA), 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 EMIA 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.*