☐ **ENROLLMENT APPLICATION** (Complete entire application.)
☐ **CHANGE FORM** (Complete entire application.)

Millard School District

LAST NAME	FIRST	INITIAL	GENDER	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	RELATIONSHIP

EMPLOYMENT STATUS: ☐ ACTIVE EMPLOYEE ☐ RETIRED (RETIREMENT DATE / /) ☐ COBRA

BENEFIT OPTIONS

MEDICAL: Care Plus PHD3200
- ☐ Employee only
- ☐ Employee plus one dependent
- ☐ Employee plus two or more dependents

MEDICAL: Care Plus PHD4000
- ☐ Employee only
- ☐ Employee plus one dependent
- ☐ Employee plus two or more dependents

MEDICAL: Care Plus PHD5000
- ☐ Employee only
- ☐ Employee plus one dependent
- ☐ Employee plus two or more dependents

DENTAL
- ☐ Employee only
- ☐ Employee plus one dependent
- ☐ Employee plus two or more dependents

LIFE
- ☐ Employee only
- ☐ Employee plus one dependent
- ☐ Employee plus two or more dependents

LONG-TERM DISABILITY
- ☐ Employee only

RELATIONSHIP TO EMPLOYEE **CODE KEY:**	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: MED	DEN	SEX	BIRTHDATE MO	DAY	YR	SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
S: Spouse		1.								
B: Biological 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 EMI Health coverage?

☐ Yes ☐ No

If so, what type of coverage? ☐ Medicare Part A ☐ Medicare Part B ☐ Medical ☐ Medical/High Deductible Plan with HSA ☐ 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 and its subsidiaries (EMI Health) 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 also understand that if I experience such a qualifying event, I may elect to terminate coverage for myself and/or my dependents by providing written notice to my employer within 31 days of the qualifying event.
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 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 ☐ DENTAL ☐ LIFE ☐ LONG-TERM DISABILITY

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

RELATIONSHIP TO EMPLOYEE **CODE KEY:** **S:** Spouse **B:** Biological Child **SC:** Step Child **A:** Adopted **O:** Other	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		MO	DAY	YR		
		7.								
		8.								
		9.								
		10.								
		11.								
		12.								

EMI HEALTH™ Smart Benefits