

Colorado River Union High School District #2

- ENROLLMENT APPLICATION (Complete entire application.)
 CHANGE FORM (Complete entire application.)

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		
EMPLOYMENT STATUS: <input type="checkbox"/> ACTIVE EMPLOYEE <input type="checkbox"/> RETIRED (RETIREMENT DATE / /) <input type="checkbox"/> COBRA						

BENEFIT OPTIONS		
MEDICAL <input type="checkbox"/> Option 1 - 500 4500 80% <input type="checkbox"/> Option 2 - 750 5000 80% <input type="checkbox"/> Option 3 - 1500 3500 80% QHDHP <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus spouse <input type="checkbox"/> Employee plus child or children <input type="checkbox"/> Family	DENTAL <input type="checkbox"/> Summit Plus Indemnity - Base Plan <input type="checkbox"/> Summit Plus Indemnity - Buy-Up Plan <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus spouse <input type="checkbox"/> Employee plus child or children <input type="checkbox"/> Family	VISION <input type="checkbox"/> VSP 130 - Base Plan <input type="checkbox"/> VSP 160 - Buy-Up Plan <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus spouse <input type="checkbox"/> Employee plus child or children <input type="checkbox"/> Family

RELATIONSHIP TO EMPLOYEE	RELATION TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED/DELETED NOTIFY EMPLOYER WITHIN 31 DAYS OF ANY CHANGE (marriage, birth, divorce, etc.).	WILL INDIVIDUAL BE COVERED FOR:			SEX	BIRTHDATE			SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
			MED	DEN	VIS		MO	DAY	YR		
CODE KEY:											
S: Spouse		1.									
B: Biological Child		2.									
SC: Step Child		3.									
A: Adopted		4.									
O: Other		5.									
		6.									
		7.									
		8.									

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 VISION

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

Signature of Applicant for Waiver Only _____ Date _____

