

# Murray School District

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

**BENEFIT OPTIONS**

<p><b>DENTAL: Choice PPO</b></p> <input type="checkbox"/> Employee only - \$39.40 <input type="checkbox"/> Employee plus one or more dependent - \$89.40 <input type="checkbox"/> Employee plus two or more dependents - \$128.50	<p><b>DENTAL: Advantage Co-Pay</b></p> <input type="checkbox"/> Employee only - \$19.90 <input type="checkbox"/> Employee plus one dependent - \$45.00 <input type="checkbox"/> Employee plus child or children - \$64.80	<p><b>LIFE</b></p> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one dependent <input type="checkbox"/> Employee plus two or more dependents
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**LONG-TERM DISABILITY**

 Employee only

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.).	SEX	BIRTHDATE			SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
				MO	DAY	YR		
<b>S:</b> Spouse		1.						
<b>B:</b> Biological Child		2.						
<b>SC:</b> Step Child		3.						
<b>A:</b> Adopted		4.						
<b>O:</b> Other		5.						
		6.						

**OTHER INSURANCE INFORMATION**

Will you, your spouse, or dependents have other dental coverage in addition to this EMI Health coverage?  
 Yes  No

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**

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Special Enrollment	<input type="checkbox"/> Name/Address Change	<input type="checkbox"/> Beneficiary Change
<input type="checkbox"/> Change of Coverage	<input type="checkbox"/> Add Family Member	<input type="checkbox"/> Cancellation	<input type="checkbox"/> Delete Family Member
<input type="checkbox"/> Other: _____			

Employer Signature \_\_\_\_\_ Effective Date \_\_\_\_\_

EMIA.EN.APP.1208.1901

Please see reverse side for waiver of group coverage.

**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.

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	RELATION TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED/DELETED NOTIFY EMPLOYER WITHIN 31 DAYS OF ANY CHANGE (marriage, first birth, divorce, etc.).	SEX	BIRTHDATE			SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
				MO	DAY	YR		
<b>CODE KEY:</b>								
<b>S:</b> Spouse		7.						
<b>B:</b> Biological Child		8.						
<b>SC:</b> Step Child		9.						
<b>A:</b> Adopted		10.						
<b>O:</b> Other		11.						
		12.						

