USEA DENTAL PLANS ENROLLMENT APPLICATION

Send this form to USEA, 864 E Arrowhead Lane, Murray, UT 84107

LAST NAME	FIRST	INITIAL	SEX	SOCIAL SECURITY NO.	DATE OF BIRTH

ADDRESS/STREET NO.	CITY & STATE	ZIP CODE

E-MAIL ADDRESS	HOME PHONE	BUSINESS PHONE

DO YOU AND/OR ANY DEPENDENTS TO BE COVERED ON THIS PLAN HAVE ANY OTHER DENTAL INSURANCE ?	IF YES, WHO IS THE SUBSCRIBER/POLICYHOLDER ?	OTHER DENTAL INSURANCE COMPANY/CARRIER

COVERED DEPENDENTS NAMES	SEX	DATE OF BIRTH	COVERED DEPENDENTS NAMES	SEX	DATE OF BIRTH
COVERED DEPENDENTS NAMES	SEX	DATE OF BIRTH	COVERED DEPENDENTS NAMES	SEX	DATE OF BIRTH
COVERED DEPENDENTS NAMES	SEX	DATE OF BIRTH	COVERED DEPENDENTS NAMES	SEX	DATE OF BIRTH

ENROLL ME IN THE FOLLOWING PLAN: ☐ PREIMER ☐ ADVANTAGE ☐ VALUE

I wish to enroll in the Educators Mutual dental plan checked above. In signing this application, I understand that the premium which are paid on my behalf by Utah School Employees Association to Educators Mutual, are my responsibility. The actual monthly premium amount deducted depends on the number of payroll deductions my district will allow for the year. I also understand that if I enroll in the Value Plan, I must pay in advance the yearly premium, which should be included with my enrollment form. Furthermore, I understand that I am responsible to notify USEA (exclusively) if there are any changes in my status regarding dental coverage and also agree to remain in the plan for a minimum of one year.

Signature ________________________________ Date___________________

The Proposed coverage shall not take effect until this application has been accepted by Educators Mutual Insurance Association. Coverage under the policy begins on the applicable effective date as stated on the face page of the policy, which will be delivered to the Subscriber through the US Postal Service.