NOTICE: YOU HAVE THE RIGHT TO SUBMIT THIS FORM DIRECTLY TO WMI MUTUAL INSURANCE COMPANY OR, AT YOUR OPTION, TO YOUR EMPLOYER

WMI® MUTUAL INSURANCE™ COMPANY P.O. BOX 572450; SALT LAKE CITY, UT 84157-2450; (800) 748-5340, Local (801) 263-8000, Fax (801) 263-1247

EMPLOYEE ENROLLMENT APPLICATION - TYPE OR PRINT CLEARLY, USE BLACK OR BLUE INK.

Employee Name	Last	First	Initial	Social Security #	Date of Birth	Sex	☐ Male ☐ Female	
Mailing Address				City	State	Zip Code	Home/Cell Phone ( )	
Name of Employer				Work Phone ( )		Date of Hire	Monthly hours worked	
Name of Spouse	Last	First	Initial	Social Security #		Date of Birth	Sex	☐ Male ☐ Female

Names of Dependents*	Last	First	Initial	Social Security #	Date of Birth	Sex	Relationship

*To be eligible for coverage, children must be under the age of 26; children are not required to reside with the employee or to be dependent upon the employee for support.

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Coverage Type: ☐ Employee ☐ Employee & Spouse (domestic partner in WA) ☐ Employee & Child ☐ Employee & Children ☐ Family

Medical Plan:

Dental*: ☐ **YES** ☐ **NO** **Vision*:** ☐ **YES** ☐ **NO** **ST Disability*:** ☐ **YES** ☐ **NO**

Group Life Insurance*: *(Amounts in excess of $25,000 require pre-approval)*

Employee Smoker / Non-Smoker **Amount:** $10,000 $25,000 $50,000 $75,000 $100,000 Other

Beneficiary: (Name) (Relationship) (Contingent)

Spouse Smoker / Non-Smoker **Amount:** $10,000 $25,000 $50,000 $75,000 $100,000 Other

Beneficiary: (Name) (Relationship) (Contingent)

Dependent(s) ☐ None ☐ One Unit ($3,000) ☐ Two Units ($6,000)

**Dental, Vision, Short Term Disability and Life Insurance are subject to employer approval.*

Employee Signature **Date**

For Office Use Only

Effective Date: _____

Termination Date: _____

VGL Amount: _____

Disability Income Amount: _____

☐ Original Group ☐ Special Enrollee

☐ New Employee ☐ Late Enrollee

Employee Name: **Social Security No.**

COORDINATION OF BENEFITS: Are you or any of your dependents currently covered under any other health insurance policy? **YES** **NO**

IF "YES", PLEASE SPECIFY BELOW.

Name of individual with other coverage	Other insurance company's name, address and phone number	Policy # and member ID # of other insurance	Effective date of other coverage	Type of other coverage: Medical/Dental/Vision

GENERAL INFORMATION (employees of Montana employers only)

Will any portion of the premium be paid by or on behalf of the employer, either directly or through wage adjustments or other means of reimbursement? Yes ___ No ___

Will any insured individual treat the health benefit plan as part of a plan or program for the purposes of sections 106, 125 or 162 of the Internal Revenue Code? Yes ___ No __

To help you answer the above question, the following information is provided: (1) Section 106 is in regard to an Archer MSA, FSA, or HSA; (2) Section 125 is in regard to a Cafeteria Plan; and (3) Section 162 is in regard to a tax deduction being allowed for expenses incurred in carrying on a trade or business.

AUTHORIZATION

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with WMI Mutual Insurance Company ("WMI"). I understand no coverage will be in force until each person listed above is approved by WMI, that no benefits will be provided for any service which begins before the coverage is effective, and that benefits will not extend beyond the termination of my coverage. I hereby declare that to the best of my knowledge and belief, the information given on this application is correctly recorded, true and complete. If I subsequently become aware of information different from that provided in this application, I agree to provide that information promptly to WMI. I understand that WMI retains the right to retroactively adjust premium rates and/or rescind coverage if necessary due to any incorrect information that is provided on this application.

Employee Signature **Date**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in any application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

WAIVER OF GROUP COVERAGE

(MUST BE COMPLETED IF ANY COVERAGE IS DECLINED OR REFUSED BY AN ELIGIBLE EMPLOYEE)

EMPLOYEE NAME _____ SOCIAL SECURITY #_____ EMPLOYER NAME _____

□ I WAIVE TOTAL COVERAGE FOR MYSELF (AND DEPENDENTS, IF ANY)

□ I WAIVE HEALTH PLAN COVERAGE FOR MYSELF (AND DEPENDENTS, IF ANY)

□ I WAIVE HEALTH PLAN COVERAGE FOR MY SPOUSE ONLY

□ I WAIVE HEALTH PLAN COVERAGE FOR MY CHILDREN ONLY

REASON FOR DECLINING COVERAGE (CHECK ONE):

□ COVERED BY SPOUSE'S COVERAGE

□ COVERED BY CHAMPUS OR CHAMPVA

□ COVERED BY HMO

□ OTHER (EXPLAIN) _____
_____

THIS IS TO ACKNOWLEDGE THAT THE AVAILABLE COVERAGES HAVE BEEN EXPLAINED TO ME BY MY EMPLOYER. I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR THE AVAILABLE COVERAGES AND HAVE ELECTED NOT TO ENROLL MYSELF AND/OR MY DEPENDENTS, IF ANY.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if employer contributions towards your or your dependent's other coverage terminate) provided that you request enrollment within 31 days after your coverage ends (within 60 days if the other coverage was Medicaid or SCHIP). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents, provided that you request enrollment within 31 days (60 days in Idaho and Washington) after the marriage, birth, adoption, or placement for adoption. To request such special enrollment, please contact the Enrollment Department, (801) 263-8000 x104 or (800) 748-5340 x104.

_____ _____

EMPLOYEE SIGNATURE DATE

WMI EE APP (1/14)