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							City State	Zip Code	Hom	e/Cell Phone
Address							Work Phone	Date of Hire	() Monthly	y hours worked
Name of Employer							()		WOTHIN	y nours worked
Name of			Last	F	irst	Initial	Social Security #	Date of Birth	Sex	☐ Male
Spouse Names of Depen	donte	k	Last	E	irst	Initial	Social Security #	Date of Birth	Sex	☐ Female Relationship
Names of Depen	uents		Last	<u> </u>	1131	IIIIIai	Oocial Security #	Date of Birtin	Jex	Relationship
*To be eligible f	for cov	erage children	must he unde	r the age of 26	S: children are r	ot required t	o reside with the employee or to	he dependent und	on the empl	ovee for support
•	_			,	_	•	• •	be dependent up	on the empi	oyee for support.
Marital Status: Coverage Type:		Single Employee	☐ Married		Separated (domestic partr	Divor	ced Employee & Child	☐ Employee 8	. Children	☐ Family
Medical Plan:				, сс и оро изс	(domestic parti	101 111 1171)	Vision*: TES		Ciliaren	ranniy
Dental*:		YES	NO (Amazanaria in		. 000	/	ST Disability*:	NO NO		
Group Life Insura Employee	ance": Smo		Non-Smoker		i,000 require pro Amount:	<i>9-approval)</i> \$10,000	\$25,000 \$50,000	\$75,000	\$100,000	Other
, ,		eficiary:				,			,	
Spouse	Smo	ker	(Name) Non-Smoker		Amount:	\$10,000	(Relationship) \$25,000 \$50,000	(Contingent) \$75,000	\$100,000	Other
Орошоо		eficiary:			Amount	Ψ10,000		Ψ7 0,000	Ψ100,000	- Cu101
Dependent(s)	П	None	(Name)	:+ (\$2,000) [□ Two Unito /	c 000)	(Relationship)	(Contingent)		
*Dependent(s) *Dental, Vision, S				it (\$3,000) [nce are subje	Two Units (Sect to employer a		For Office Use Only Effective Date:			
		·		•	, ,		Termination Date:			•
Employee Signat	ture			П	ate	_	VGL Amount: Disability Income Amount:			•
Employee eighan	·ui ·			_	ato					·
							□ Original G	roup		al Enrollee
							☐ Original G			al Enrollee Enrollee
Employee							□ New Emp	loyee 		
Employee Name:							□ New Emp	loyee 		
Name: COORDINATION				ny of your dep	endents curren	tly covered u	□ New Emp	No.		
Name: COORDINATION		ENEFITS:	W.			•	Social Security I	No. policy?	Late E	NO
Name: COORDINATION IF "YES", PLEA	ASE S	PECIFY BELO	W. Other ins	urance compa	endents curren	•	□ New Emp Social Security I	No. policy? Effective date of	□ Late E YES	Enrollee
Name: COORDINATION	ASE S	PECIFY BELO	W. Other ins	urance compa	ıny's name, add	•	Social Security I nder any other health insurance Policy # and member ID # of	No. policy?	□ Late E YES	NO other coverage:
Name: COORDINATION IF "YES", PLEA	ASE S	PECIFY BELO	W. Other ins	urance compa	ıny's name, add	•	Social Security I nder any other health insurance Policy # and member ID # of	No. policy? Effective date of	□ Late E YES	NO other coverage:
Name: COORDINATION IF "YES", PLEA	ASE S	PECIFY BELO	W. Other ins	urance compa	ıny's name, add	•	Social Security I nder any other health insurance Policy # and member ID # of	No. policy? Effective date of	□ Late E YES	NO other coverage:
Name: COORDINATION IF "YES", PLEA	ASE S	PECIFY BELO	W. Other ins	urance compa	ıny's name, add	•	Social Security I nder any other health insurance Policy # and member ID # of	No. policy? Effective date of	□ Late E YES	NO other coverage:
Name: COORDINATION IF "YES", PLEA	al with	other coverage	Other ins	urance compa phone	ny's name, add number	•	Social Security I nder any other health insurance Policy # and member ID # of	No. policy? Effective date of	□ Late E YES	NO other coverage:
Name: COORDINATION IF "YES", PLEA Name of individua GENERAL INFOR	al with	other coverage ON (employees	Other ins	urance compa phone	ny's name, add number	Iress and	Social Security I nder any other health insurance Policy # and member ID # of other insurance	No. Effective date of other coverage	YES Type of Medica	NO other coverage:
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COORDINATION IF "YES", PLEA Name of individua GENERAL INFOR Will any portion of Will any insured in To help you an a Cafeteria Pla	RMATI f the prodividure and	other coverage ON (employeestemium be paid all treat the heal the above questi	Other inso	employers o alf of the emplo	nly) over, either dire olan or program	ctly or throug for the purp	Social Security I Inder any other health insurance Policy # and member ID # of other insurance th wage adjustments or other moses of sections 106, 125 or 16 of is in regard to an Archer MSA	eans of reimburser 2 of the Internal Re A, FSA, or HSA; (2)	YES Type of Medica	NO other coverage: Il/Dental/Vision No e? Yes No
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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		REASON FOR DECLINING COVERAGE (CHECK ONE):
(AND DEPENDENTS, IF ANY)		COVERED BY CROUGES COVER A CE
☐ I WAIVE HEALTH PLAN COVERAGE FOR MYSE	RI E	□ COVERED BY SPOUSE'S COVERAGE
(AND DEPENDENTS, IF ANY)	SLI	□ COVERED BY CHAMPUS OR CHAMPVA
□ I WAIVE HEALTH PLAN COVERAGE FOR MY SE	POUSE ONLY	□ COVERED BY HMO
□ I WAIVE HEALTH PLAN COVERAGE FOR MY CI	HILDREN ONLY	OTHER (EXPLAIN)
the future be able to enroll yourself or your dependents employer contributions towards your or your dependen	in this plan if you or your depe at's other coverage terminate) p	because of other health insurance coverage, you may in ndents lose eligibility for that other coverage (or if rovided that you request enrollment within 31 days after your ion, if you have a new dependent as a result of marriage, birth,
		lents, provided that you request enrollment within 31 days
		or adoption. To request such special enrollment, please contact the
Enrollment Department, (801) 263-8000 x104 or (800) 7	748-5340 x104.	

WMI EE APP (1/14)