

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	<input type="checkbox"/> Male <input type="checkbox"/> 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	<input type="checkbox"/> Male <input type="checkbox"/> 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 if eligible*) Employee & Child Employee & Children Family
Medical Plan: _____ **Vision*:** YES NO
Dental*: 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**

*Check with your employer to determine if domestic partner coverage is available.

For Office Use Only	
Effective Date:	_____
Termination Date:	_____
VGL Amount:	_____
Disability Income Amount:	_____
<input type="checkbox"/> Original Group	<input type="checkbox"/> Special Enrollee
<input type="checkbox"/> New Employee	<input type="checkbox"/> Late Enrollee

Employee Name:	Social Security No.
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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

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 _____

- | | |
|---|--|
| <p><input type="checkbox"/> I WAIVE TOTAL COVERAGE FOR MYSELF
(AND DEPENDENTS, IF ANY)</p> <p><input type="checkbox"/> I WAIVE HEALTH PLAN COVERAGE FOR MYSELF
(AND DEPENDENTS, IF ANY)</p> <p><input type="checkbox"/> I WAIVE HEALTH PLAN COVERAGE FOR MY SPOUSE ONLY</p> <p><input type="checkbox"/> I WAIVE HEALTH PLAN COVERAGE FOR MY CHILDREN ONLY</p> | <p>REASON FOR DECLINING COVERAGE (CHECK ONE):</p> <p><input type="checkbox"/> COVERED BY SPOUSE'S COVERAGE</p> <p><input type="checkbox"/> COVERED BY CHAMPUS OR CHAMPVA</p> <p><input type="checkbox"/> COVERED BY HMO</p> <p><input type="checkbox"/> OTHER (EXPLAIN) _____
_____</p> |
|---|--|

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 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