2025 Dental & Vision Enrollment

Please complete and email this form to AskHR@imail.org

Intermountain Health

5245 South College Drive
Salt Lake City, UT 84123
833.442.7547

APPLICANT Information

Retiree name (First, Middle, Last)	**Social Security Number**	**Retirement Date**
Address	**Phone number**	
City	**State**	**ZIP Code**
Email address	**Date of birth**	

DENTAL Plan Election (Check one only. Premiums are the same for both plans.)

☐ **Utah Plan**	☐ **Out of Utah Plan**	☐ **Do NOT enroll me in the Dental Plan**

DENTAL Coverage Requested

☐ **Individual**	☐ **Double**	☐ **Family** (three or more participants)

Monthly Dental Insurance Premiums

Type of Coverage	2025 Premium
Individual	$32.00
Double	$68.00
Family*	$117.00

VISION Plan Election (You cannot enroll in vision unless you enroll in dental above)

☐ **Enroll me in the Vision Plan**	☐ **Do NOT enroll me in the Vision Plan**

VISION Coverage Requested

☐ **Individual**	☐ **Double**	☐ **Family** (three or more participants)

*Family coverage is retiree & two or more dependents.

Monthly Vision Insurance Premiums

Type of Coverage	2025 Premium
Individual	$5.29
Double	$10.05
Family*	$14.76

COVERED Participants

Relationship to retiree	**Names of participants to be covered**	**Social Security #**	**Gender**	**Date of birth** (month, day, year)	**Name of other health insurance carrier and policy #**
Retiree				/ /	☐ YES ☐ NO
Spouse				/ /	☐ YES ☐ NO
Child				/ /	☐ YES ☐ NO
Child				/ /	☐ YES ☐ NO

SIGNATURE OF SUBSCRIBER MUST BE COMPLETED BELOW TO VALIDATE APPLICATION. On the reverse side of this application, terms and conditions are listed which are an integral part of your application for benefits. Please read those provisions carefully. By signing, you acknowledge that you have read and understand the provisions of this plan including those contained on the reverse side of this form. **Important note: Dental and vision cancellations are always effective Dec. 31 of the current year. You cannot cancel mid-year.**

Subscriber signature:_____ **Date:** _____

WAIVER OF COVERAGE ☐ I wish to discontinue my dental insurance benefits. I choose not to participate in these dental insurance benefits for myself, my dependent(s) or my heirs, and hereby waive such coverage. I understand I can only re-elect for this coverage during annual enrollment.
Subscriber signature:_____ Date: _____

EMPLOYER USE: Coverage code:_____ **Effective date/retiree coverage**_____ **Pension Connect Input** ☐
SH Link Input ☐ **Intermountain authorization**_____**Date**_____**Code:**_____**Premium:** _____

Instructions

- **General Information:** Please print your answers in either black or blue ink in all unshaded blanks. Employer use areas are for the use of SelectHealth and Intermountain Healthcare. Incomplete and/or illegible information may result in delayed coverage. If any item is not applicable, write "N/A." Be sure to sign and date the form.
- **Member information:** Please check the dental insurance program you have selected which is offered by your employer. Include your current address to ensure all pertinent mailing information will reach you. Your Social Security number is critical as all claims for you and your dependents are processed using your Social Security number. Please keep in mind that dental and vision cancellations are effective December 31 of the calendar year in which you are enrolled. You cannot cancel mid-year. You can only cancel or enroll during the annual enrollment period which is held every fall.
- **Enrolled members:** Including yourself, please list the gender, name, birthdate (month, day and year) and Social Security number of every eligible dependent to be covered under the requested insurance program. Please list surnames of dependents which differ from yours. For every dependent covered by another group plan, complete the appropriate dental carrier name(s). Make sure complete information is given for every dependent covered by other plans for coordination of benefits. Incomplete information may result in delayed claims processing. If you decline enrollment in this plan for yourself and/or any of your dependents (including your spouse) because of other dental insurance coverage, you may in the future be able to enroll the omitted individual(s) in this plan during the next calendar year after the other coverage of the individual(s) ends. ("Decline enrollment" includes omission of the individual from this application).

Terms and conditions of application

I authorize any source to release SelectHealth (hereinafter referred to as "the Plan") any dental, employment and/or insurance information requested on any enrolled member. I authorize payroll deduction of premiums as required. I agree to abide by the Plan's enrollment provisions. I understand that coverage cannot start until after I have served the waiting period agreed to by the employer as recorded on the Plan's records. I authorize my employer to act as my agent in all matters of administration of the group program and acknowledge that my employer is in no way acting as agent for the Plan. I understand there may not be participating dentists available in all specialty fields. Any matter in dispute between you and the Plan may be subject to arbitration as an alternative to court action pursuant to the rules of, the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration, including but not limited to: attorney fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both you and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction. I further certify that all information completed on this form is true and correct and acknowledge my coverage is subject to cancellation if any completed information is found to be false or incorrect.