

2027 Dental & Vision Enrollment

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



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 (Select one option 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 ☐ Two participants ☐ Family (three or more participants)

Monthly Dental Insurance Premiums

Type of Coverage	2027 Premium
Individual	\$36.00
Two participants	\$78.00
Family*	\$135.00

Vision Plan Election (You must enroll in dental coverage to enroll in vision coverage.)

☐ Enroll me in the Vision Plan ☐ Do not enroll me in the Vision Plan

Vision Coverage Requested

☐ Individual ☐ Two participants ☐ Family (three or more participants)

Monthly Vision Insurance Premiums

Type of Coverage	2027 Premium
Individual	\$5.91
Two participants	\$10.93
Family*	\$15.36

*Family coverage is retiree & two or more dependents.

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 all answers clearly in black or blue ink and complete all unshaded blanks. Areas marked for employer use are for SelectHealth and Intermountain Healthcare only. Incomplete or illegible information may delay coverage. If an item does not apply, write "N/A." Be sure to sign and date the form.
- **Member Information:** Select the dental insurance program offered by your employer. Provide your current address so you receive all important mailings. Your Social Security number is required because claims for you and your dependents are processed using that number. Dental and vision cancellations are effective December 31 of the calendar year in which you are enrolled. You cannot cancel mid-year. You may cancel or enroll only during the annual enrollment period held each fall.
- **Covered Participants:** List yourself and each eligible dependent to be covered. Include each participant's gender, full name, date of birth, and Social Security number. If a dependent's last name differs from yours, include the dependent's last name clearly. For any dependent covered by another group plan, provide the dental carrier's name so benefits can be coordinated. Missing information may delay claims processing. If you decline enrollment for yourself or a dependent because of other dental coverage, you may be able to enroll the omitted person during the next calendar year after that other coverage ends.

Terms and Conditions of Application

Authorization and Enrollment: I authorize any source to release to SelectHealth, referred to in this section as "the Plan," any dental, employment, and insurance information requested for any enrolled member. I authorize payroll deduction of required premiums and agree to follow the Plan's enrollment provisions. I understand that coverage cannot begin until I have completed the waiting period agreed to by the employer and recorded in the Plan's records.

Employer Role: I authorize my employer to act as my agent in matters related to administration of the group program. I understand that my employer is not acting as an agent for the Plan.

Availability of Participating Dentists: I understand that participating dentists may not be available in every specialty field.

Dispute Resolution: Any dispute between you and the Plan may be subject to arbitration as an alternative to court action under the rules of the American Arbitration Association or another recognized arbitrator. A copy of those rules is available from the Plan upon request. The Plan will pay arbitration costs, filing fees, administrative fees, and arbitrator fees. Each party is responsible for its own other arbitration expenses, including attorney fees, discovery expenses, witnesses, stenographers, translators, and similar costs. Any arbitration decision is binding on both you and the Plan. The arbitration award may include attorney fees if allowed by state law and may be entered as a judgment in any court with proper jurisdiction.

Certification: I certify that all information provided on this form is true and correct. I understand that coverage may be canceled if any completed information is found to be false or incorrect.