SUU SOUTHERN UTAH UNIVERSITY
Human Resources
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Cedar City, UT 84720
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EMI HEALTH Smart Benefits Formerly Educators Mutual

Traditional Medical Insurance Plan Switch Form (Open Enrollment for 2018-2019)

This form must be completed and turned into the SUU Human Resources office by June 1, 2018.

Employee Name _____ T-Number _____

☐ ***Yes, I am electing to switch back to the University's traditional medical insurance option from the Qualified High Deductible Health Plan effective July 1, 2018 (the start of fiscal year 2019). I understand this will mean I will be required to pay the applicable employee premiums to participate in the traditional medical insurance option.***

Level of Coverage under the Traditional Plan: ☐ Single ☐ Couple ☐ Family

If you have selected couple or family coverage above, please list your dependents on the plan*:

Spouse's Name _____ Spouse's Birthdate _____

Child's Name _____ Child's Birthdate _____ Married Child? _____

Child's Name _____ Child's Birthdate _____ Married Child? _____

Child's Name _____ Child's Birthdate _____ Married Child? _____

Child's Name _____ Child's Birthdate _____ Married Child? _____

Child's Name _____ Child's Birthdate _____ Married Child? _____

Child's Name _____ Child's Birthdate _____ Married Child? _____

**The HR office may request additional information from you (such as SSN) if these records were not provided to us at an earlier date or time of initial health insurance enrollment.*

I hereby acknowledge that:

- I am voluntarily switching back to the University's traditional health plan for Fiscal Year 2019 and will be unable to change my medical insurance option (i.e. back to the HDHP plan) again until the next benefits open enrollment period.
- This switch will have no impact on my current benefit coverage under the University's dental and/or vision plan.
- I understand, with this switch, that my contributions into a Health Savings Account (HSA) will stop as of June 30, 2018.
- I understand that, effective July 1 2018, I will be ineligible to contribute further to my existing Health Savings Account due to this change in insurance coverage. However, I understand that I can continue to use funds in my existing Health Savings Account (or save them for future use) without a penalty.
- I will be eligible to contribute to a Flexible Spending Account for health care expenses under the traditional plan option.
- I authorize EMI Health to share personal health information concerning me and my family, including adult dependents, with any health care provider providing benefits. I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- I understand that I am not entitled to change my coverage level during the plan year unless I experience a special enrollment situation (i.e. marriage, divorce, birth, death, adoption, or loss of other insurance coverage). I understand that if I do experience such a qualifying event, I may elect to terminate coverage for myself and/or my dependents by providing written notice to my employer within 31 days of the qualifying event.

_____ _____

Employee Signature Date