

Credit Union Name		Group Plan No. 5900	
Planholder Street Address c/o UMFS, 2366 US 41 South	City Marquette	State MI	Zip 49855
PLEASE CHECK REASON FOR COMPLETING: <input checked="" type="checkbox"/> INITIAL APPLICATION			
CHANGE: <input type="checkbox"/> ADD DEPENDENT(S) <input type="checkbox"/> TERMINATE A FAMILY MEMBER <input type="checkbox"/> ADDRESS <input type="checkbox"/> NAME <input type="checkbox"/> DELETE COVERAGE			
DATE OF CHANGE ___ / ___ / ___ REASON FOR CHANGE _____			
GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED			
Name (Last, First, Middle Initial)	Sex	Birthdate	Member Social Security #
Member:	<input type="checkbox"/> M <input type="checkbox"/> F		
Spouse:	<input type="checkbox"/> M <input type="checkbox"/> F		Date of Marriage / /
Child: ...	<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
***** I understand that Dental enrollment is locked in for 12 consecutive months. <input type="checkbox"/> Yes <input type="checkbox"/> No initial _			
Member's Street Address		City	
State		Zip	
Home Phone		Business Phone	

VISION

Member: I elect	<input type="checkbox"/> Bronze Schedule – Vision Plan (4000)
<ul style="list-style-type: none"> ▪ I hereby apply for the group benefit(s) indicated above. ▪ I authorize monthly deductions from my debit/credit card. ▪ The information provided above is true and correct to the best of my knowledge. ▪ Any person, who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. 	
X SIGNATURE OF MEMBER	DATE

Please retain a photocopy for your records and submit this form to

UPPER MICHIGAN FINANCIAL SERVICES

2366 US 41 South

Marquette, MI 49855

(906)249-7665 / (888)534-9103

(906) 249-6640 (FAX)



Bronze Plan

Single	\$11.00
Two Person	\$19.00
Family	\$26.00

*12 Month Commitment applies to this plan

- Hearing Aid Discount
- Free Phone Consultation on Medicaid Planning
- Receive Prescription Discounts
- 24 Hour Nurse Hotline
- Vitamin Discounts and Free Shipping
- You Can Purchase A Chiropractic Plan
- Healthy Living Awareness Articles
- Nutritional Articles From Doctors
- Healthy Recipes Each Month
- You Can Purchase an Aetna Individual Health Insurance Plan
- Having An Aetna Plan With us You Will Receive

Additional Benefits for the Platinum Plan



- Delta Vision Plan
 - Every 12 Months Eye Exam
 - Every 12 Months Frames
 - Every 12 Months Lens or Contacts

Insurance will be effective the first day of the upcoming month.

 [Delta Dental Application Form](#)

Additional Benefits Such As:

Discounts on exercise equipment and supplies
 Discounts on gym memberships
 Acupuncture Therapy
 Massage Therapy
 Nutritional Counseling

- You Can Purchase an Aetna Medicare Plan
- You Can Purchase:
 - Short Term Disability
 - Heart & Stroke
 - Sickness Indemnity

Free Downloads



- - Nutrition Log
 - Strength Training Logs
 - Medication Flowsheet

- Accident Insurance
- Cancer Insurance
- Term Insurance

This can be your financial safety net!

*This webpage is for illustrative purposes only. You will receive benefit booklets. If there is a discrepancy between this webpage and your benefit booklet, the benefit booklet prevails.