Summit

P.O. Box 25160
Scottsdale, AZ 85255-0102

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NEW HIRE ENROLLMENT FORM ☐ **CHANGE FORM ☐** **ACTIVE ☐** **RETIREE ☐** **LIFE ONLY ☐**

SECTION 1 - EMPLOYEE INFORMATION:

Employer: **YUMA UNION HIGH SCHOOL DISTRICT #70** Date of Hire: _____Social Security Number: _____

Last Name: _____ First Name: _____Initial:_____

Address: _____City: _____ State: _____ Zip Code: _____

Employee's Sex: ☐ Male ☐ Female Date of Birth: _____ Phone Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Is your spouse a District Employee?** ☐ Yes ☐ No

Plan Options (Please initial choice)

☐ Base Plan _____(INITIALS) Medical/Dental/RX

☐ Base Plan w/Vision _____(INITIALS) Medical/Dental/RX/Vision

☐ Buy-Up Plan_____(INITIALS) Medical/Dental/RX

☐ Buy-Up Plan w/Vision_____(INITIALS) Medical/Dental/RX/Vision

Enrollment Options (Please initial choice)

☐ Employee Only_____(INITIALS)
☐ Employee +Child(ren)_____(INITIALS)
☐ Employee + Spouse_____(INITIALS)
☐ Employee + Family_____(INITIALS)
☐ Employee + Employee + Child(ren)_____(INITIALS)
☐ Employee + Employee_____(INITIALS

DEPENDENT INFORMATION: ☐ **Add** ☐ **Terminate** **(List eligible dependents to be enrolled in health Plan)**

NAME OF DEPENDENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP

SECTION 2 - TO ADD OR CHANGE COVERAGE: if change is due to marriage, birth, divorce or loss of coverage; show date and reason.

Reason For Change:_____ Date:_____

SECTION 3 - OTHER COVERAGE INFORMATION (Only if covered under our plan):

Do you or your family have other health insurance coverage including Medicare? ☐ Yes ☐ No

Name of other Policyholder: _____

If my plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I represent that all statements and answers made in this application and on any attached paper, are complete and true to the best of my knowledge and belief. I agree that: (1) No coverage will be effective until the effective date assigned by the plan administrators, following its approval of this application; (2) No agent has authority to waive any requirement or a complete answer to any question; (3) My employer shall represent me when receiving notices (including contribution and termination notices), when transmitting change requests and other information and when paying contribution for this coverage.

I authorize any physician, medical facility, insurer, employer, having information as to employment, medical coverage, or medical care, treatment or advice for any physical or mental condition of me, my spouse, or my children, or any other non-medical information, to give such information to Summit or its administrators to determine eligibility for coverage. I agree that the company may release such information to its representatives or reinsurers or as permitted by law. This authorization is valid for the duration of coverage under this plan. A copy is valid as the original. I understand that any charge involved for the cost of these records will be my responsibility.

Signature: _____ **Date:** _____

District Office Use Only

Effective Date:_____Group Number: **217** District Representative:_____

Reason for change: _____