



☐ NEW HIRE ENROLLMENT FORM ☐ CHANGE FORM ☐ ACTIVE ☐ RETIREE ☐ LIFE ONLY **Group #217**

SECTION 1 - EMPLOYEE INFORMATION:

Employer: YUMA UNION HIGH SCHOOL DISTRICT #70 Social Security Number: _____
Last Name: _____ First Name: _____ Initial: _____ Gender: ☐ Male ☐ Female
Physical Address: _____ City: _____ State: _____ Zip Code: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Phone Number: _____

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

Plan Options (Please initial choice)

☐ **Mexico Plan** _____ (Initials) Medical//RX ☐ **Base Plan** _____ (Initials) Medical/Dental/RX ☐ **Base Plan with Vision** _____ (Initials) Medical/Dental/RX/Vision
☐ **Buy-Up Plan** _____ (Initials) Medical/Dental/RX ☐ **Buy-Up Plan with Vision** _____ (Initials) Medical/Dental/RX/Vision

Enrollment Options (Please initial choice)

☐ Employee Only _____ (Initials) ☐ Employee + Family _____ (Initials)
☐ Employee + Children _____ (Initials) ☐ Employee + Employee + Child(ren) _____ (Initials)
☐ Employee + Spouse _____ (Initials) ☐ Employee + Employee _____ (Initials)

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

NAME OF DEPENDENT	SOCIAL SECURITY #	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: Do you or your family have other health insurance coverage **including Medicare?** ☐ Yes ☐ No

Name of other Insurance and 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 ADMINISTRATION USE ONLY

☐ New Hire: Date of Hire: _____ ☐ Full Time ☐ Part Time Effective date of Coverage: _____ Annual Salary \$ _____ Group # **217**
☐ Employee is Dependent Spouse under: Employee Name (with Family coverage): _____
☐ Leave of Absence or FMLA Start Date: _____
☐ Add or Drop Dependents: Qualifying event (QE) _____ Date of QE: _____ Eff date of change: _____
☐ Reason for Termination: _____ Date of Termination: _____
Measurement Period Applies ☐ No ☐ Yes - ☐ Look Back or ☐ Monthly **FOR H.R.:** Employee Meets Eligibility: ☐ No ☐ Yes-Initials: _____
District Representative Signature: _____ Date: _____



P: (480) 505-0400 P.O. Box 25160
F: (480) 505-0406 Scottsdale, AZ 85255-0102
T: (888) 690-2020 www.summit-inc.net