Summit

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HOPI JR/SR HIGH SCHOOL
MEDICAL ENROLLMENT FORM

Member/Employee's Last Name	**First**	**Middle initial**
Date of Birth:	**Gender:**	**Telephone No:**	**Social Security No:**
Address:	**City:**	**State:**	**Zip:**

Are you or any of your dependents covered under any other health plan? G**Yes** G**No**
If Yes, Name of Insured: **Insurance Co.:** **Insurance Company Telephone No.:**

Eligible Dependents To Be Enrolled

Last/First Name	Date of Birth	Relationship	Social Security No.

AUTHORIZATION TO ENROLL FOR COVERAGE

If my employer's plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay on a **pre-tax** basis.

Notice of enrollment rights: I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage maybe subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after such marriage, birth, adoption, or placement for adoption.

Employee Signature: _____ **Date** _____

WAIVER OF COVERAGE

I decline coverage for:

- □ Myself
- □ Spouse
- □ Dependent Child(ren)
- □ Myself and all dependents

WAIVER OF COVERAGE

The above named employer / sponsor has offered medical benefits to me; after careful consideration, I have elected to decline acceptance of these benefits and I have instead obtained similar benefits as evidenced by a copy of my ID card enclosed. I further agree that should I desire to enroll in the employer / sponsor plan at a later date, I will not be able to do so until the next open enrollment. This declination does not affect any life insurance or accidental death benefits that may be offered by the employer / sponsor.

Employee Signature: _____ **Date** _____

Employer / Administrator Use Only

□ New Hire/Open Enrollment			**□ Termination Date** ____/____/___
□ Add/Delete Dependents (Must include Documentation & Date of Qualifying Event)			
□ Marriage ____/____/____		**□ Divorce:** ____/_____/ ____	**□ Other:** ____/____/____
□ New Birth: ____/____/____	**□ Adoption:** ____/____/____	**Explain:**	
□ Address Change	**□ COBRA Continuation**	**□ Late Enrollee**	**□ Reason for Termination** _____
GROUP #293	**9 NA Code A** **9 NN Code B**	**Date of Hire**	**Coverage Effective Date**