SUMMIT

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ENROLLMENT FORM
MEDICAL & RX
Walker River Paiute Tribe #445

Tribal Member: Yes No

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? ☐ Yes ☐ 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

❑ I hereby authorize my employer to deduct any health plan contribution that may be due from my pay check. I further understand that I must continue coverage and the contributions from my pay check for my dependent's coverage until either the next open enrollment or until I have a Special Enrollment Event as specified in the benefit booklet.

On behalf of myself and any enrolled dependents on this form ("us"), I authorize any health care professional or entity to give vendors associated with this Plan or their affiliates (and the employer) or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for the purpose of identification. I understand and agree that any omission or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the Plan Administrator after it has been approved by the Third Party Administrator and after the full contribution has been paid. By signing this form, I hereby certify that all the information provided is true and correct.

❑ I WAIVE coverage.

Employee Signature: _____ Date _____

EMPLOYER / ADMINISTRATOR USE ONLY

☐ New Hire/Date of Hire: __/____/____ ☐Termination Date: ___/____/___ ☐ Reason for Termination

Measurement Period Applies ☐ No ☐ Yes ☐ Look Back or ☐ Monthly For H.R,: Employee Meets Eligibility ☐ No ☐ Yes Initials: _____

☐ Add/Delete Dependents (For Open Enrollment, provide month/year of Open Enrollment period.) Open Enrollment Date:

☐ Add/Delete Dependents (For Special Enrollment Event, if not during Open Enrollment, check reason below, provide date & proof of event)

☐ Marriage Date:____/____/____ ☐ Divorce/Legal Separation Date: ____/_____/ _ ☐ New Birth: ____/____/____

☐ Adoption: ____/____/__☐ Loss of Other Coverage: _/____/__ Reason for Loss of Other Coverage:

☐ Address Change

Coverage Effective Date: / /	