THE HOPI TRIBE

ENROLLMENT / CHANGE FORM

SUMMIT

Office of Human Resources
PO Box 123
Kykotsmovi, AZ 86039
(928) 734-3212
(928) 734-6611 Fax
HumanResources@hopi.nsn.us

PO Box 25160
Scottsdale, AZ 85255-0102
(480) 505-0400
Fax (480) 505-0406
Toll Free 1 (888) 690-2020
www.summit-inc.net

☐ **The Hopi Tribe**	☐ **Hopi Tribal Housing Authority**	☐ **Hopi Credit Association**
☐ **Village of Tewa**	☐ **Village of Walpi**	☐ **Village of Kykotsmovi**

Employee's Last Name, First Name, Middle Initial	
Address: P.O. Box, City, State, Zip Code	Please check one: ☐ Native ☐ Non-Native

Date of Birth:	Gender:	Social Security Number:	Telephone Number:
	☐ Male ☐ Female		

Are you or any of your dependents entitled to benefits under any other health plan? ☐ Yes ☐ No

If yes, Name of Insured Below:	Insurance Company:	Telephone Number:

Are you eligible for benefits through IHS? ☐ Yes ☐ No

Eligible Dependents to Be Enrolled

Last / First Name	**Date of Birth**	**Social Security No.**	**Relationship**
Select Plan Coverage ☐Medical ☐Dental ☐Vision			
Select Plan Coverage ☐Medical ☐Dental ☐Vision			
Select Plan Coverage ☐Medical ☐Dental ☐Vision			
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Select Plan Coverage ☐Medical ☐Dental ☐Vision			
Select Plan Coverage ☐Medical ☐Dental ☐Vision			

AUTHORIZATION TO ENROLL FOR COVERAGE

I 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 folder.

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 coverage for me and/or my dependents. 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 had been paid. By signing this form, I hereby certify that all information provided is true and correct.

Employee Signature: _____ Date: _____

AUTHORIZATION TO WAIVE COVERAGE

The above named employer/sponsor has offered medical, dental and/or vision benefits to me: after careful consideration, I have elected to decline acceptance of these benefits. 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 period. This declination does not affect any life insurance or accidental death benefits that may be offered by the employer/sponsor.

BENEFITS DECLINED I DECLINE COVERAGE FOR**:**

☐Myself	☐Medical ☐Dental ☐Vision
☐Spouse	☐Medical ☐Dental ☐Vision
☐Dependent Children	☐Medical ☐Dental ☐Vision
☐Myself and all dependents	☐Medical ☐Dental ☐Vision

Employee Signature: _____ Date: _____

EMPLOYER / ADMINISTRATOR USE ONLY		
NEW HIRE INFORMATION ☐ Full Time DOH: ☐ Seasonal* DOH: ☐ Temporary* DOH: **Regularly scheduled to work 30 hours per work week. Eligible for Medical ONLY.*		
TERMINATION Date:	**Reason for Termination:**	
☐ 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.)		
☐ Marriage Date:	**☐ Divorce/Legal Separation Date:**	**☐ New Birth:**
☐ Adoption:	**☐ Loss of Other Coverage:**	**Reason for Loss of Other Coverage:**
☐ Address Change		
Coverage Effective Date:	**Annual Salary:**	**Salary Effective Date:**