

Required Information

In the last 6 months, has the policyholder or any dependent(s) used any tobacco product at least 4 times a week (such as cigarettes, snuff, chewing tobacco or any nicotine substitution product)? Yes No
If yes, indicate who: Policyholder Spouse/Civil Union Spouse Dependent Children

Section B: Plan Selection

Please choose one plan.

Summit Plan Name	
Summit HSA 6500 Bronze	<input type="checkbox"/>
Summit 5500 Bronze	<input type="checkbox"/>
Summit 4100 Silver	<input type="checkbox"/>

POS Plan Name	
POS 1500 Gold	<input type="checkbox"/>

Additional coverage.

Vision	
VSP Vision Choice Plan \$20 exam copay	<input type="checkbox"/>

Section C: Signature and Date

Policyholder Signature _____ Signature Date _____

I agree that the typed name above shall be treated as a valid signature for all purposes of this form.

↓ FOR OFFICE AND BROKER USE ONLY ↓

Agent Name: _____

Agency: _____