ARAG® Legal Insurance Enrollment Form

Please mail completed form to:
Return to your ACT Campus Director,
Effective 1/1/2021

For assistance to complete this form, call 800-247-4184

1. ENROLLEE INFORMATION

Name in Full

First M.I. Last

Employer/Association Affiliation

Name of Employer/Association
Chaffey Joint Union High School District #18730

Mailing Address

Number and Street

City State Zip Code

Employee ID

Date of Birth

Month Day Year

Gender

M / F

Daytime Telephone Number

- - ext.

Date of Hire/Last Date of Employment/Date of Retirement

Month Day Year

Email Address

2. PLAN SELECTION AND FAMILY INFORMATION (Please Complete Applicable Information)

UltimateAdvisor®

☐ : $21.90 (10- Pay)

UltimateAdvisor Plus™

☐ : $25.20 (10 - Pay)

☐ **Cancel my participation**

Spouse/Domestic Partner First Name Last Name Gender - M/F DOB: MM/DD/YY

Dependent First Name Last Name Gender - M/F DOB: MM/DD/YY

Dependent First Name Last Name Gender - M/F DOB: MM/DD/YY

Dependent First Name Last Name Gender - M/F DOB: MM/DD/YY

Dependent First Name Last Name Gender - M/F DOB: MM/DD/YY

3. AUTHORIZATION

By signing below, I am requesting enrollment or cancellation in the legal plan indicated above. I understand that the change in coverage will not become effective until the date assigned by the underwriter of the plan. I authorize my employer to deduct or cancel deductions for the cost of the plan as shown above, and as may be modified or adjusted, from my wages or salary.

Enrollee Signature Date MM/DD/YYYY

X

Limitations and exclusions apply. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa, GuideOne® Mutual Insurance Company of West Des Moines, Iowa or GuideOne Specialty Mutual Insurance Company of West Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits or exclusions, call 800-247-4184.

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