# Enrollment Form

## How to complete your enrollment form

Thank you for choosing Priority Health. To help make your life easier, here are some instructions for completing this form. Please remember, if the form is not complete and accurate, this may cause a delay in processing your coverage for you and your dependents.

A few reminders before you get started:

- Please print clearly using blue or black ink
- If you have any questions or need assistance while completing this form, please call us at 616 464-8550 or 866 464-5257

| | |
|---|---|
| **Section 1: Employee Information** | This information is about the person who will be carrying the insurance.<br>*The completion of the race/ethnicity information is optional. The information will be protected and will not affect your access to health care services, benefits, eligibility or premiums. This information will help Priority Health to monitor and improve the quality of care for members. |
| **Section 2: Waiver of Coverage (if applicable)** | Complete this section if you choose not to accept coverage by Priority Health for you, your spouse or dependents. |
| **Section 3: Dependent Information** | This information must be completed if you would like coverage for your spouse and dependents.<br>**Reminder**: If your dependent is over the age of 19 and is a full-time student, you must also complete SECTION 4 and attach proof of full-time student status.<br>*The completion of race/ethnicity information is optional. The information will be protected and will not affect your access to health care services, benefits, eligibility or premiums. This information will help Priority Health to monitor and improve the quality of care for members. |
| **Section 4: Dependents age 19 and over with full-time student status** | Complete this section if your dependent is a full-time student and over the age of 19.<br>**Reminder**: To help us validate this coverage, be sure to attach proof of student status (acceptable documents to attach are registration or class schedule). |
| **Section 5: Other Insurance Information** | Complete this section if you, your spouse, or dependents will have coverage under another health plan or policy including Medicare. This will help us coordinate your benefits with your other insurance coverage.<br>**Reminder**: Be sure to attach a copy of your other medical insurance coverage ID card. |
| **Section 6: Authorization** | Your signature is needed to let us know that you will abide by the Certificate of Coverage and/or Summary Plan Description that applies to our coverage. |

**Plan type:** ☐ Standard ☐ Enhanced **Plan level:** ☐ Single ☐ Double ☐ Single & child(ren) ☐ Family

## SECTION 1 - EMPLOYEE INFORMATION

*Please use only blue or black ink*

Employee Last Name | First Name | MI | Social Security Number

Street Address

City | State | Zip Code | Gender ☐ MALE ☐ FEMALE

Home Phone | Work Phone | Birth Date | Marital Status ☐ Single ☐ Separated ☐ Widowed ☐ Married ☐ Divorced

e-mail Address | Race/Ethnicity (Optional)* ☐ White/Caucasian ☐ Hispanic/Latino ☐ Other ☐ Black/African American ☐ Asian

Employee's Priority Health Primary Care Provider (PCP) (REQUIRED IF HMO) | PCP Code

Are you a current patient? ☐ Yes ☐ No Employee covered by other insurance? (If yes, complete section 5) ☐ Yes ☐ No

## SECTION 2 - REFUSAL OF COVERAGE (IF APPLICABLE)

*Please use only blue or black ink*

I hereby certify that I have been offered coverage under the Benefit Plan(s) sponsored by my Employer, and have decided NOT to take advantage of this offer. If I request to add coverage at a later date, I will be subject to the terms and limitations as described in the Summary Plan Description.

COVERAGE REFUSED:

- ☐ Medical Coverage for Myself
- ☐ Dental Coverage for Myself
- ☐ Vision Coverage for Myself
- ☐ Other ____________
- ☐ Medical Coverage for my Eligible Dependents
- ☐ Dental Coverage for my Eligible Dependents
- ☐ Vision Coverage for my Eligible Dependents
- ☐ Flexible Spending
- ☐ Other ____________

Employee Signature: ______________________ Date: ______________

## SECTION 3 - DEPENDENT INFORMATION

*Please use only blue or black ink*

If your dependent is over age 19 and a full-time student, you must also complete section 4.
Please list spouse and/or dependents who will be covered under this policy (if you have more than 4 please complete an additional Enrollment Form).

**1** Spouse

☐ Medical ☐ Dental ☐ Vision

Last Name | First Name | MI | Gender ☐ MALE ☐ FEMALE

Social Security Number | Birth Date | e-mail Address

Primary Care Provider Name (REQUIRED IF HMO/EPO) | PCP Code | Race/Ethnicity (Optional)* ☐ White/Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Other

Are you a current patient? ☐ Yes ☐ No

**2**

☐ Natural Child ☐ Step Child ☐ Other

☐ Medical ☐ Dental ☐ Vision

Last Name | First Name | MI | Gender ☐ MALE ☐ FEMALE

Social Security Number | Birth Date | e-mail Address

Primary Care Provider Name (REQUIRED IF HMO/EPO) | PCP Code | Race/Ethnicity (Optional)* ☐ White/Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Other

Are you a current patient? ☐ Yes ☐ No

**3**

☐ Natural Child ☐ Step Child ☐ Other

☐ Medical ☐ Dental ☐ Vision

Last Name | First Name | MI | Gender ☐ MALE ☐ FEMALE

Social Security Number | Birth Date | e-mail Address

Primary Care Provider Name (REQUIRED IF HMO/EPO) | PCP Code | Race/Ethnicity (Optional)* ☐ White/Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Other

Are you a current patient? ☐ Yes ☐ No

**4**

☐ Natural Child ☐ Step Child ☐ Other

☐ Medical ☐ Dental ☐ Vision

Last Name | First Name | MI | Gender ☐ MALE ☐ FEMALE

Social Security Number | Birth Date | e-mail Address

Primary Care Provider Name (REQUIRED IF HMO/EPO) | PCP Code | Race/Ethnicity (Optional)* ☐ White/Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Other

Are you a current patient? ☐ Yes ☐ No

Employee Name (last, first): ____________________

## SECTION 4 - DEPENDENTS AGE 19 AND OVER FULL TIME STUDENT STATUS

*Please use only blue or black ink*

Dependent Last Name | First Name | MI | Registrar / Business Office Phone

School/Institution Name | Number of Credit Hours | Semester Enrolled | Eligible IRS Dependent ☐ Yes ☐ No

School Address

## SECTION 5 - OTHER INSURANCE INFORMATION

*Please use only blue or black ink*

Are you, your spouse, or any dependents covered by Medicare or any other insurance policy providing benefits? ☐ Yes *(Please complete this section)* ☐ No

WHERE ARE CLAIMS SENT?

Insurance Company Name | Company Address

POLICYHOLDER INFORMATION

Name of Policyholder | Birth date | Policy Effective Date

Employer

REASON FOR MEDICARE

☐ Over Age 65 ☐ Over Age 65 and Working
☐ End Stage Renal Stage Disease ☐ Disabled

Medicare Claim Number | Effective Date

Family Member(s) Covered

Family Member Last Name | First Name | MI

REASON FOR MEDICARE

☐ Over Age 65 ☐ Over Age 65 and Working
☐ End Stage Renal Stage Disease ☐ Disabled

Medicare Claim Number | Effective Date

Family Member Last Name | First Name | MI

Family Member Last Name | First Name | MI

Family Member Last Name | First Name | MI

## SECTION 6 - AUTHORIZATION

I am applying for coverage for each person listed above and agree that we will abide by the Certificate of Coverage and/or Summary Plan Description that applies to our coverage.

Employee Signature: ____________________ Date: ____________

**EMPLOYER: PLEASE COMPLETE THIS SECTION**
(Instructions on the back)

Group Number | Sub Group Number | Class

Company Name | Contact Phone | Date of Hire

Effective Date | e-mail Address

**ENROLLMENT**

PLEASE CHECK ALL APPLICABLE BOXES

**TYPE** ☐ Union ☐ Non-Union ☐ Salary ☐ Hourly | **RETIREE** ☐ Early Retiree (Under 65) ☐ Retiree (65+) ☐ Surviving Spouse

**REASON** ☐ New Hire ☐ New Group ☐ Open Enrollment ☐ Re-Hire ☐ QMSCO ☐ Loss of Coverage ☐ Other____________

**COBRA Continuation** ☐ 18 months ☐ 27 months ☐ 36 months Qualifying event date ___/___/____ COBRA effective date ___/___/____

COVERAGE (AS APPLICABLE)

**HEALTH** ☐ HMO ☐ EPO ☐ POS ☐ PPO ☐ IND | **PPO NETWORK** ____________

**DENTAL** ☐ Single ☐ Family ☐ High ☐ Low | **VISION** ☐ Single ☐ Family ☐ High ☐ Low | **CEH** ☐ HRA ☐ HSA ☐ HBC ☐ HBCI

**HEALTH OPTION** (IF APPLICABLE) ☐ High ☐ Mid ☐ Low | **LIFE** Life Amount $ __________ Short Term Disability $__________ AD&D $ __________

Company Representative Signature: ____________________ Date: ____________

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# Employer Enrollment Form

## How to complete your employer section

Thank you for choosing Priority Health. Here are some helpful tips to help with processing coverage for your employees.

- Please print clearly using blue or black ink
- If you have any questions or need assistance while completing this form, please call us at 616 464-8550 or 866 464-5257
- Remember, employer signature is required for processing

| | |
|---|---|
| **Group Number** | List your Priority Health group number to ensure proper benefits and billing. |
| **Sub Group Number** | If your group has more than one subgroup, please list the appropriate subgroup number (S001, S002…). |
| **Class** | List the appropriate class to indicate active, retired, or specific group location (CA01, CA02, CC01, RE01...). |
| **Your Company Name, e-Mail and Contact Phone Number** | Complete your company name, phone number and e-mail address. |
| **Date of Hire** | For new groups, new hires and open enrollments |
| **Effective Date** | Indicate the requested effective date of coverage (the effective date of coverage is subject to your Group Agreement language). |
| **Enrollment Section** | Remember to check applicable boxes for Type, Retiree, and Reason<br>Remember to check applicable boxes for Coverage (Health, PPO Network, Dental, Vision, CEH, Health Option, and Life). |
| **Company Representative Signature** | Your signature is needed to verify the employee's eligibility for coverage. |

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