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 616 464-8850 or 800 464-5257

Section	Instructions
Section 1: Employee Information	This information is about the person who will be carrying the insurance. *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. **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. *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. **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. **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.

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

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)* ☐ Hispanic/Latino ☐ White/Caucasian ☐ Asian ☐ Black/African American ☐ Other

Are you a current patient? ☐ Yes ☐ No

2 ☐ Natural Child ☐ Step Child

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)* ☐ Hispanic/Latino ☐ White/Caucasian ☐ Asian ☐ Black/African American ☐ Other

Are you a current patient? ☐ Yes ☐ No

3 ☐ Natural Child ☐ Step Child

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)* ☐ Hispanic/Latino ☐ White/Caucasian ☐ Asian ☐ Black/African American ☐ Other

Are you a current patient? ☐ Yes ☐ No

4 ☐ Natural Child ☐ Step Child

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)* ☐ Hispanic/Latino ☐ White/Caucasian ☐ Asian ☐ Black/African American ☐ 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 Address

Number of Credit Hours | Semester Enrolled

Eligible IRS Dependent ☐ Yes ☐ No

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

Medicare Claim Number

☐ End Stage Renal Stage Disease ☐ Disabled

☐ Over Age 65 ☐ Over Age 65 and Working

Effective Date

Family Member(s) Covered

Family Member Last Name | First Name | MI

REASON FOR MEDICARE

Medicare Claim Number

☐ End Stage Renal Stage Disease ☐ Disabled

☐ Over Age 65 ☐ Over Age 65 and Working

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: ________________

The term "Priority Health" refers to three corporations: "Priority Health", "Priority Health Managed Benefits, Inc." and "Priority Health Insurance Company". Priority Health is a registered trademark and is used by permission of the owner.

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 616 464-8850 or 800 464-5257
- 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 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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