# Enrollment form

Priority Health

All information must be completed to process form.
Incomplete forms will be returned and not processed.

## Employee information

| Employee Legal Last Name | Legal First Name | Middle initial | Social Security number<br>– – |
|---|---|---|---|

| Street address | City | State | ZIP code |
|---|---|---|---|

| Phone<br>( ) | Work phone<br>( ) | Gender<br>☐ Male ☐ Female | Birth date (month/day/year)<br>/ / |
|---|---|---|---|

| Email address | Race/ethnicity (optional) ☐ Hispanic/Latino ☐ Asian ☐ White/Caucasian ☐ Black/African American ☐ Other | Marital status ☐ Divorced ☐ Widowed ☐ Single ☐ Married |
|---|---|---|

| **Are you or any of your dependents covered under another insurance plan? If yes, please provide the following information:** | Other carrier information | Effective date of coverage |
|---|---|---|

| Primary Care Provider (doctor) First and Last Name | Priority Health Provider ID *(This can be found on priorityhealth.com/findadoc)* | Are you a current patient?<br>☐ Yes ☐ No |
|---|---|---|

| Doctor street address | City | State | ZIP code |
|---|---|---|---|

**Authorization**
Your signature is needed to let us know that you will abide by an insurance policy, a Certificate of Coverage, an Explanation of Coverage, or a Summary Plan Description that applies to your coverage.

| Employee signature<br>X _____ | Today's date<br>/ / |
|---|---|

## To be completed by employer (form cannot be processed without this information)

| Original date of hire | **For re-hire employee** – Date of re-hire<br>/ / | Eligibility date<br>/ / | Effective date<br>/ / |
|---|---|---|---|

| Group number | Subgroup number | Class |
|---|---|---|

| Company name |
|---|

| Company phone<br>( ) | Email address |
|---|---|

**Please check all applicable boxes**

**Type** ☐ Union ☐ Non-Union ☐ Salary ☐ Hourly

**Retiree** ☐ Early retiree (under 65) ☐ Retiree (65+) ☐ Surviving spouse

**Reason** ☐ New hire ☐ Open enrollment ☐ QMCSO (proof required) ☐ Change of employment status ☐ New group ☐ Re-hire ☐ Move into service area ☐ Loss of coverage ☐ Birth ☐ Marriage ☐ Adoption (proof required) ☐ Other _____

**COBRA continuation** ☐ 18 months ☐ 29 months (proof required) ☐ 36 months ☐ Qualifying event date: _____ ☐ COBRA effective date: _____

**Coverage** (if applicable)

**Health Plan** ☐ HMO open access ☐ EPO ☐ POS open access ☐ PPO ☐ Indemnity

**PPO network**

**Health option (if applicable)** ☐ High ☐ Mid ☐ Low

☐ HSA ☐ HRA ☐ PriorityWell Choice Benefits

**Dental** ☐ Single ☐ Double ☐ Family

**Vision** ☐ Single ☐ Double ☐ Family

| **Employer signature**<br>**X** _____ | **Today's date**<br>**/ /** |
|---|---|

**Dependent information** (Your spouse, domestic partner and eligible children you wish to enroll)

**1**

☐ Spouse
☐ Domestic partner
☐ Child
☐ Stepchild
☐ Other:

*If applicable*

☐ Dental
☐ Vision

| | | | |
|---|---|---|---|
| Dependent legal last name | Legal first name | Middle initial | Social Security number - - |
| Gender ☐ Male ☐ Female | Birth date (month/day/year) / / | Email address | Race/Ethnicity (optional) |
| Dependent street address | | | |
| City | State | ZIP code | Is this address outside of the Priority Health service area? ☐ Yes ☐ No |
| Covered under another insurance plan? ☐ Yes ☐ No<br>If different from above, please provide other carrier information and effective date. | | | |
| Primary Care Provider (doctor) First and Last Name | Priority Health Provider ID | Are you a current patient? ☐ Yes ☐ No | |
| Doctor street address | City | State | ZIP code |

**2**

☐ Child
☐ Stepchild
☐ Other:

*If applicable*

☐ Dental
☐ Vision

| | | | |
|---|---|---|---|
| Dependent legal last name | Legal first name | Middle initial | Social Security number - - |
| Gender ☐ Male ☐ Female | Birth date (month/day/year) / / | Email address (for dependents 18 and older)* | Race/Ethnicity (optional) |
| Dependent street address | | | |
| City | State | ZIP code | Is this address outside of the Priority Health service area? ☐ Yes ☐ No |
| Covered under another insurance plan? ☐ Yes ☐ No<br>If different from above, please provide other carrier information and effective date | | | |
| Primary Care Provider (doctor) First and Last Name | Priority Health Provider ID | Are you a current patient? ☐ Yes ☐ No | |
| Doctor street address | City | State | ZIP code |

**3**

☐ Child
☐ Stepchild
☐ Other:

*If applicable*

☐ Dental
☐ Vision

| | | | |
|---|---|---|---|
| Dependent legal last name | Legal first name | Middle initial | Social Security number - - |
| Gender ☐ Male ☐ Female | Birth date (month/day/year) / / | Email address | Race/Ethnicity (optional) |
| Dependent street address | | | |
| City | State | ZIP code | Is this address outside of the Priority Health service area? ☐ Yes ☐ No |
| Covered under another insurance plan? ☐ Yes ☐ No<br>If different from above, please provide other carrier information and effective date. | | | |
| Primary Care Provider (doctor) First and Last Name | Priority Health Provider ID | Are you a current patient? ☐ Yes ☐ No | |
| Doctor street address | City | State | ZIP code |

**4**

☐ Child
☐ Stepchild
☐ Other:

*If applicable*

☐ Dental
☐ Vision

| | | | |
|---|---|---|---|
| Dependent legal last name | Legal first name | Middle initial | Social Security number - - |
| Gender ☐ Male ☐ Female | Birth date (month/day/year) / / | Email address (for dependents 18 and older)* | Race/Ethnicity (optional) |
| Dependent street address | | | |
| City | State | ZIP code | Is this address outside of the Priority Health service area? ☐ Yes ☐ No |
| Covered under another insurance plan? ☐ Yes ☐ No<br>If different from above, please provide other carrier information and effective date | | | |
| Primary Care Provider (doctor) First and Last Name | Priority Health Provider ID | Are you a current patient? ☐ Yes ☐ No | |
| Doctor street address | City | State | ZIP code |

**5**

☐ Child
☐ Stepchild
☐ Other:

*If applicable*

☐ Dental
☐ Vision

| | | | |
|---|---|---|---|
| Dependent legal last name | Legal first name | Middle initial | Social Security number - - |
| Gender ☐ Male ☐ Female | Birth date (month/day/year) / / | Email address | Race/Ethnicity (optional) |
| Dependent street address | | | |
| City | State | ZIP code | Is this address outside of the Priority Health service area? ☐ Yes ☐ No |
| Covered under another insurance plan? ☐ Yes ☐ No<br>If different from above, please provide other carrier information and effective date. | | | |
| Primary Care Provider (doctor) First and Last Name | Priority Health Provider ID | Are you a current patient? ☐ Yes ☐ No | |
| Doctor street address | City | State | ZIP code |


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