

Enrollment Form



Priority Health • PO Box 205 • Grand Rapids, MI 49501-0205

SECTION 1 - EMPLOYEE INFORMATION

Employee's Last Name		First Name		Middle Initial	Social Security Number - -	
Street Address			City		State	Zip Code
Home Phone () -	Work Phone () -	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date / /	E-mail Address		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Employee's Priority Health Primary Care Provider (PCP) (REQUIRED for HMO & POS)				
Have you seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP Address/ID Code				
PRODUCT <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> HBC <input type="checkbox"/> HSA			OPTION (If Applicable) <input type="checkbox"/> ENHANCED <input type="checkbox"/> BASIC			

Please list spouse and/or dependents who will be covered under this policy (if you have more than 4 dependents please complete an additional Enrollment Form).

1	Spouse/Dependent's Last Name		First Name		Middle Initial	Social Security Number - -
	Birth Date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relation to Employee		E-mail Address	
	Primary Care Provider (PCP) (REQUIRED for HMO & POS)		Has the dependent seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP Address/ID Code	
2	Spouse/Dependent's Last Name		First Name		Middle Initial	Social Security Number - -
	Birth Date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relation to Employee		E-mail Address	
	Primary Care Provider (PCP) (REQUIRED for HMO & POS)		Has the dependent seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP Address/ID Code	
3	Spouse/Dependent's Last Name		First Name		Middle Initial	Social Security Number - -
	Birth Date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relation to Employee		E-mail Address	
	Primary Care Provider (PCP) (REQUIRED for HMO & POS)		Has the dependent seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP Address/ID Code	
4	Spouse/Dependent's Last Name		First Name		Middle Initial	Social Security Number - -
	Birth Date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relation to Employee		E-mail Address	
	Primary Care Provider (PCP) (REQUIRED for HMO & POS)		Has the dependent seen this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP Address/ID Code	

SECTION 2 - COORDINATION OF BENEFITS

If you, your spouse, or any dependents are covered by Medicare or any other insurance policy providing medical benefits, please complete this section.

WHERE ARE CLAIMS SENT?	Company Name		Company Address			
POLICYHOLDER INFORMATION	Name of Policyholder		Birthdate / /	Policy Effective Date / /	Employer	
	Family Member(s) Covered (1) (2) (3) (4)					
REASON FOR MEDICARE	<input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disabled <input type="checkbox"/> Over Age 65 <input type="checkbox"/> Over Age 65 and Working					Medicare Effective Date / /

SECTION 3 - AUTHORIZATION

I apply 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. I understand the Priority Health cannot process my Enrollment Form on time unless I fill in all the information above, in particular, list a PCP for my enrolled dependents and myself. All of the information I have given above is complete and correct. If the Group Plan requires that I make contributions, I authorize my employer to deduct them from my pay.

Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.

Employee Signature X _____ Date: _____

For Employer Use Only	Employer			Work Location of Employee		
	Employer Representative Signature				Date / /	
	Group Number		Sub Group Number	Class	Date of Hire / /	Effective Date / /
	PLEASE CHECK ALL APPLICABLE BOXES:	TYPE <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Cobra			RETIREE <input type="checkbox"/> Early Retiree (Under 65) <input type="checkbox"/> Retiree (65+)	
		LONG TERM DISABILITY <input type="checkbox"/> Date of Disability / /				
REASON <input type="checkbox"/> New Hire <input type="checkbox"/> New Group <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of Other Coverage Reason: _____						
For Priority Health Use Only	COBRA CONTINUATION <input type="checkbox"/> 18 Month <input type="checkbox"/> 29 Month <input type="checkbox"/> 36 Month		Qualifying Event Date / /		Effective Date / /	
	Date Received	Processor	Code	Date Processed		