Enrollment form

PriorityHealth

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

Employee information

Employee last name	First name	Middle initial	Social Security number - -

Street address	City	State	ZIP code

Phone ( )	Work phone ( )	Gender ☐ Male ☐ Female	Birth date (month/day/year) / /

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

Primary Care Provider (doctor) last name	Doctor first name	Are you a current patient? ☐ 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 X _____	**Today's date** / /

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

Original date of hire	**For re-hire employee** – Date of re-hire / /	Eligibility date / /	Effective date / /

Group number	Subgroup number	Class

Company name	SHOP ID (if plan purchased on SHOP)

Company phone ( )	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 (proof required) ☐ Birth ☐ Marriage ☐ Other _____

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

Coverage (if applicable)

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

PPO network

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

Consumer engaged health plan ☐ HRA ☐ HSA ☐ HBCA ☐ HBCR ☐ HBCI ☐ HBCM

Dental ☐ Single ☐ Double ☐ Family

Vision ☐ Single ☐ Double ☐ Family

Employer signature X _____	**Today's date** / /

ority Health Enrollment — White Priority Health Employer — Yellow Employee — Pink

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

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

If applicable

☐ Dental
☐ Vision

Dependent last name	First name	Middle initial	Social Security number - -
Gender ☐ Male ☐ Female	Birth date (month/day/year) / /	Email address	
Dependent street address			
City	State	ZIP code	Is this address outside of the Priority Health service area? ☐ Yes ☐ No
Primary Care Provider (doctor) last name	Doctor first name	Are you a current patient? ☐ Yes ☐ No	
Doctor street address	City	State	ZIP code

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☐ Child
☐ Stepchild
☐ Other: _____

If applicable

☐ Dental
☐ Vision

Dependent last name	First name	Middle initial	Social Security number - -
Gender ☐ Male ☐ Female	Birth date (month/day/year) / /	Email address (for dependents 18 and older)*	
Dependent street address			
City	State	ZIP code	Is this address outside of the Priority Health service area? ☐ Yes ☐ No
Primary Care Provider (doctor) last name	Doctor first name	Are you a current patient? ☐ Yes ☐ No	
Doctor street address	City	State	ZIP code

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☐ Child
☐ Stepchild
☐ Other: _____

If applicable

☐ Dental
☐ Vision

Dependent last name	First name	Middle initial	Social Security number - -
Gender ☐ Male ☐ Female	Birth date (month/day/year) / /	Email address (for dependents 18 and older)*	
Dependent street address			
City	State	ZIP code	Is this address outside of the Priority Health service area? ☐ Yes ☐ No
Primary Care Provider (doctor) last name	Doctor first name	Are you a current patient? ☐ Yes ☐ No	
Doctor street address	City	State	ZIP code

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☐ Child
☐ Stepchild
☐ Other: _____

If applicable

☐ Dental
☐ Vision

Dependent last name	First name	Middle initial	Social Security number - -
Gender ☐ Male ☐ Female	Birth date (month/day/year) / /	Email address (for dependents 18 and older)*	
Dependent street address			
City	State	ZIP code	Is this address outside of the Priority Health service area? ☐ Yes ☐ No
Primary Care Provider (doctor) last name	Doctor first name	Are you a current patient? ☐ Yes ☐ No	
Doctor street address	City	State	ZIP code

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☐ Child
☐ Stepchild
☐ Other: _____

If applicable

☐ Dental
☐ Vision

Dependent last name	First name	Middle initial	Social Security number - -
Gender ☐ Male ☐ Female	Birth date (month/day/year) / /	Email address (for dependents 18 and older)*	
Dependent street address			
City	State	ZIP code	Is this address outside of the Priority Health service area? ☐ Yes ☐ No
Primary Care Provider (doctor) last name	Doctor first name	Are you a current patient? ☐ Yes ☐ No	
Doctor street address	City	State	ZIP code