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	Birth date (month/day/year)
( )	( )	☐ Male ☐ Female	/ /

Email address	Race/ethnicity (optional)	Marital status
	☐ Hispanic/Latino ☐ Asian ☐ White/Caucasian ☐ Black/African American ☐ Other	☐ 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	Today's date
x _____	/ /

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

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

Group number	Subgroup number	Class
791176		

Company name: Epic Excavating

Company phone	Email address
( )	linda@epicexcavating.net

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 ☐ IND

PPO network

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

CEH ☐ HRA ☐ HSA ☐ HBCA ☐ HBCR ☐ HBCI ☐ HBCM

Dental ☐ Single ☐ Double ☐ Family

Vision ☐ Single ☐ Double ☐ Family

Life Life amount $ _____ Short-term disability $ _____ AD&D $ _____

Employer signature	Today's date
x _____	/ /

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

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☐ Spouse
☐ 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	
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	
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	
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	
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