

Enrollment Form Instructions



Employees

Thank you for choosing Priority Health. Please complete this form for yourself and any family members you wish to cover.

A few reminders to help you complete this form:

- Please print clearly using blue or black ink.
- ALL sections of this form must be completed in order to process coverage for you and your family. If it is not complete and accurate, the form will be sent back to you, and this will cause a delay in processing coverage for you and your family.
- If you have any questions or need assistance while completing this form, please call us at 800 446-5674 or 616 942-1221.

Employee information

This information is about the person who will be carrying the insurance.

This information must be completed if you would like coverage for your spouse and family members.

Family information

Please list spouse and/or family members who will be covered under this policy. If you have more than 4, please complete an additional enrollment form.

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 our coverage.

*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.

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.

In accordance with the Genetic Information Nondiscrimination Act (GINA) of 2008, Priority Health requests that you not include any genetic information on this form. Genetic information includes any genetic testing results of either yourself or a family member, your family health history, or any requests for or receipt of genetic services.

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Enrollment Form



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 |
| Home phone () () | Work phone () () | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Birth date (month/day/year) / / | |
| E-mail address | Race/ethnicity (optional) <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black/African American | <input type="checkbox"/> Asian <input type="checkbox"/> Other | Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed |
| Primary Care Physician (PCP) | | PCP address | Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| Family information (Your spouse and eligible children you wish to enroll). | | | | | |
|--|---|---|--|-------------------------------|----------|
| 1 <input type="checkbox"/> Spouse | Spouse last name | First name | Middle initial | Social Security number - - | |
| | Birth date (month/day/year) / / | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | E-mail address | | |
| | Primary Care Physician (PCP) | PCP address | Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Race/ethnicity (optional)* <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Other | | | | |
| 2 <input type="checkbox"/> Natural/ Adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other | Family member last name | First name | Middle initial | Social Security number - - | |
| | Birth date (month/day/year) / / | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | E-mail address | | |
| | School or family member's permanent address | | City | State | Zip code |
| | Primary Care Physician (PCP) | PCP address | Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Race/ethnicity (optional)* <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Other | | | | |
| 3 <input type="checkbox"/> Natural/ Adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other | Family member last name | First name | Middle initial | Social Security number - - | |
| | Birth date (month/day/year) / / | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | E-mail address | | |
| | School or family member's permanent address | | City | State | Zip code |
| | Primary Care Physician (PCP) | PCP address | Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Race/ethnicity (optional)* <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Other | | | | |

continued >

| | | | | | | |
|--|---|---|---|------|----------------|--|
| 4 | Family member last name | | First name | | Middle initial | Social Security number - - |
| | Birth date (month/day/year) / / | | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | | E-mail address | |
| | School or family member's permanent address | | | City | State | Zip code |
| | Primary Care Physician (PCP) | | PCP address | | | Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Natural/ Adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other | | Race/ethnicity (optional)* <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Other | | | | |

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 | |
| Company name | | |
| Company phone () | E-mail address | |

| | | | | |
|-----------------------------------|--|---|--|--|
| Please check all applicable boxes | Type <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Salary <input type="checkbox"/> Hourly | | Retiree <input type="checkbox"/> Early retiree (under 65) <input type="checkbox"/> Retiree (65+) <input type="checkbox"/> Surviving spouse | |
| | Reason <input type="checkbox"/> New hire <input type="checkbox"/> Open enrollment <input type="checkbox"/> QMSCO <input type="checkbox"/> Other _____ <input type="checkbox"/> New group <input type="checkbox"/> Re-hire <input type="checkbox"/> Loss of coverage (submit proof) | | | |
| | COBRA continuation <input type="checkbox"/> 18 months <input type="checkbox"/> 29 months <input type="checkbox"/> 36 months <input type="checkbox"/> Qualifying event date: _____ <input type="checkbox"/> COBRA effective date: _____ | | | |
| Coverage (as applicable) | Health <input type="checkbox"/> HMO open access <input type="checkbox"/> EPO <input type="checkbox"/> POS open access <input type="checkbox"/> PPO <input type="checkbox"/> IND | | PPO network: _____ | |
| | Dental <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> High <input type="checkbox"/> Low | Vision <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> High <input type="checkbox"/> Low | CEH <input type="checkbox"/> HRA <input type="checkbox"/> HSA <input type="checkbox"/> HBCA <input type="checkbox"/> HBC <input type="checkbox"/> HBCI | |
| | Health option (if applicable) <input type="checkbox"/> High <input type="checkbox"/> Mid <input type="checkbox"/> Low | | Life Life amount \$ _____ Short-term disability \$ _____ AD&D \$ _____ | |

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 our coverage.

| | |
|---------------------------|---------------------|
| Employee signature | Today's date |
| X _____ | |
| Employer signature | Today's date |
| X _____ | |

For internal use

| | | |
|------------------------|-----------------|-------------|
| Contract number | Initials | Date |
| | | |

Enrollment Form Instructions



Employers

Thank you for choosing Priority Health for your employees.

To help us process enrollment forms in a timely manner, follow these simple tips:

- Please print clearly using blue or black ink.
- If you have any questions or need assistance while completing this form, please call us at 616 464-8550 or 866 464-5257.
- Remember to sign the form. We cannot enroll your employee and family members without your signature.

| | |
|---|---|
| Group number | List your Priority Health group number to ensure proper benefits and billing. |
| Subgroup 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. |