

# Enrollment Form Instructions



## Employees

Thank you for choosing Priority Health. To help make your life easier, here are some instructions for completing this form. Please remember, if the form is not complete and accurate, this may cause a delay in processing your coverage for you and your dependents.

A few reminders before you get started:

- Please print clearly using blue or black ink.
- If you have any questions or need assistance while completing this form, please call us at 800 446-5674 or 616 942-1221.

<b>Section 1: Employee information</b>	This information is about the person who will be carrying the insurance.  *The completion of the 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.
<b>Section 2: Dependent information</b>	This information must be completed if you would like coverage for your spouse and dependents.  Please list spouse and/or dependents who will be covered under this policy. If you have more than 4, please complete an additional enrollment form.  *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.  <b>Reminder:</b> If your dependent is over the age of 19 and is a full-time student, be sure to fill in the required information and attach proof of student status (acceptable documents to attach are registration or class schedule).
<b>Section 3: Authorization</b>	Your signature is needed to let us know that you will abide by the Certificate of Coverage and/or Summary Plan Description that applies to our coverage.

*continued >*

## Section 1 - 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/date/year) / /	
E-mail address (required)		Race/ethnicity (Optional) <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Other		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
Primary Care Provider (PCP), required if HMO, EPO, POS		Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP address/ID code		Employee covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No

## Section 2 - Dependent information

<b>1</b>  <input type="checkbox"/> Spouse <input type="checkbox"/> Natural child <input type="checkbox"/> Step child	Spouse/dependent's last name		First name		Middle initial	Social Security Number - -	
	Birth date / /		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Relationship to policy holder	E-mail address	
	Primary Care Provider (PCP), required if HMO, EPO, POS		Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP address/ID code			
	Dependent covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Race/ethnicity (Optional) <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Other				
	Dependent age 19 and over full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		School name				
	School address			City	State	Zip code	
	Registrar/business office phone ( )		Number of credit hours	Semester enrolled		Eligible IRS dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2</b>  <input type="checkbox"/> Natural child <input type="checkbox"/> Step child	Spouse/dependent's last name		First name		Middle initial	Social Security Number - -	
	Birth date / /		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Relationship to policy holder	E-mail address	
	Primary Care Provider (PCP), required if HMO, EPO, POS		Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP address/ID code			
	Dependent covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Race/ethnicity (Optional) <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Other				
	Dependent age 19 and over full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		School name				
	School address			City	State	Zip code	
	Registrar/business office phone ( )		Number of credit hours	Semester enrolled		Eligible IRS dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>3</b>  <input type="checkbox"/> Natural child <input type="checkbox"/> Step child	Spouse/dependent's last name		First name		Middle initial	Social Security Number - -	
	Birth date / /		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Relationship to policy holder	E-mail address	
	Primary Care Provider (PCP), required if HMO, EPO, POS		Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP address/ID code			
	Dependent covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Race/ethnicity (Optional) <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Other				
	Dependent age 19 and over full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		School name				
	School address			City	State	Zip code	

*continued >*

<b>3</b>	School address		City	State	Zip code	
	Registrar/business office phone ( )	Number of credit hours	Semester enrolled		Eligible IRS dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>4</b>	Spouse/dependent's last name		First name	Middle initial	Social Security Number - -	
	Birth date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to policy holder	E-mail address		
	Primary Care Provider (PCP), required if HMO, EPO, POS		Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP address/ID code		
	Dependent covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		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	
	Dependent age 19 and over full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		School name			
	School address		City	State	Zip code	
	Registrar/business office phone ( )	Number of credit hours	Semester enrolled		Eligible IRS dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Section 3 - Authorization

I am applying 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.

Employee signature

Date

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.

<b>Employer: Please complete this section</b>	Group number		Subgroup number		Class	
	Company name			Date of hire	Effective date	
	Contact phone ( )		E-mail address			
	Company representative signature				Date	
	<b>Please check all applicable boxes</b>	<b>Type</b> <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Salary <input type="checkbox"/> Hourly		<b>Retiree</b> <input type="checkbox"/> Early Retiree (under 65) <input type="checkbox"/> Retiree (65+) <input type="checkbox"/> Surviving Spouse		
		<b>Reason</b> <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				
		<b>COBRA continuation</b> <input type="checkbox"/> 18 months <input type="checkbox"/> 27 months <input type="checkbox"/> 36 months <input type="checkbox"/> Qualifying event date: _____ <input type="checkbox"/> COBRA effective date: _____				
	<b>Coverage (as applicable)</b>	<b>Health</b> <input type="checkbox"/> HMO <input type="checkbox"/> EPO <input type="checkbox"/> POS <input type="checkbox"/> PPO <input type="checkbox"/> IND		<b>PPO network:</b> _____		
		<b>Dental</b> <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> High <input type="checkbox"/> Low		<b>Vision</b> <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> High <input type="checkbox"/> Low		<b>CEH</b> <input type="checkbox"/> HRA <input type="checkbox"/> HSA <input type="checkbox"/> HBC <input type="checkbox"/> HBCI
		<b>Health option (if applicable)</b> <input type="checkbox"/> High <input type="checkbox"/> Mid <input type="checkbox"/> Low		<b>Life</b> Life amount \$ _____ Short-term disability \$ _____ AD&D \$ _____		

# Enrollment Form Instructions



## Employers

Thank you for choosing Priority Health. Here are some helpful tips to help with processing coverage for your employees.

- 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, employer signature is required for processing

<b>Group number</b>	List your Priority Health group number to ensure proper benefits and billing.
<b>Subgroup number</b>	If your group has more than one subgroup, please list the appropriate subgroup number (S001, S002...).
<b>Class</b>	List the appropriate class to indicate active, retired, or specific group location (CA01, CA02, CC01, RE01...).
<b>Your company name, e-mail and contact phone number</b>	Complete your company name, phone number and e-mail address.
<b>Date of hire</b>	For new groups, new hires and open enrollments
<b>Effective date</b>	Indicate the requested effective date of coverage (the effective date of coverage is subject to your Group Agreement language).
<b>Enrollment section</b>	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).
<b>Company representative signature</b>	Your signature is needed to verify the employee's eligibility for coverage.