PriorityDental and **Priority**Vision Enrollment form instructions

PriorityHealth

Employees

Thank you for choosing Priority Health. Please complete this form for yourself and any dependents 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.
Prior dental coverage	If you were previously covered with another dental carrier, please provide the carrier name, contract number and group number.
Dependent information	This information must be completed if you would like coverage for your spouse and family members. Please list spouse and/or family members who will be covered under this policy. If you have more than 5, 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 the Summary Plan Description that applies to your coverage.

continued >

Social Security number is required by Federal law for members age 45-64.

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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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

Previous dental coverage?

☐ No ☐ Yes If yes, carrier name _____ Contract number _____ Group number _____

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

Company name

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)

Dental
Plan ☐ A ☐ B ☐ C ☐ With Ortho ☐ Without Ortho
Annual Plan Maximum ☐ $1000 ☐ $1500
Does waiting period apply? ☐ Yes ☐ No

Vision
Plan ☐ C ☐ E ☐ G ☐ H

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**

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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**

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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**

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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**

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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**

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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**

PriorityDental and **Priority**Vision Enrollment form instructions

PriorityHealth

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, etc.).
Class	List the appropriate class to indicate active, retired or specific group location (CA01, CA02, CC01, RE01, etc.).
Your company name, email and contact phone number	Complete your company name, phone number and email 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 dental or vision coverage.
Company representative signature	Your signature is needed to verify the employee's eligibility for coverage.