Enrollment Form Instructions

PriorityHealth®

Employees

Thank you for choosing Priority Health. Please complete this form for youself 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.
Family 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 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.

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

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

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

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

Primary Care Physician (PCP)	PCP address	Are you a current patient?
		☐ Yes ☐ No

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

1 ☐ Spouse

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

Birth date (month/day/year)	Gender	E-mail address
/ /	☐ Male ☐ Female	

Primary Care Physician (PCP)	PCP address	Are you a current patient?
		☐ Yes ☐ No

Race/ethnicity (optional)*
☐ Hispanic/Latino ☐ Asian ☐ White/Caucasian ☐ Black/African American ☐ Other

2 ☐ Natural/Adopted child ☐ Stepchild ☐ Other

Family member last name	First name	Middle initial	Social Security number
			- -

Birth date (month/day/year)	Gender	E-mail address
/ /	☐ Male ☐ Female	

School or family member's permanent address	City	State	Zip code

Primary Care Physician (PCP)	PCP address	Are you a current patient?
		☐ Yes ☐ No

Race/ethnicity (optional)*
☐ Hispanic/Latino ☐ Asian ☐ White/Caucasian ☐ Black/African American ☐ Other

3 ☐ Natural/Adopted child ☐ Stepchild ☐ Other

Family member last name	First name	Middle initial	Social Security number
			- -

Birth date (month/day/year)	Gender	E-mail address
/ /	☐ Male ☐ Female	

School or family member's permanent address	City	State	Zip code

Primary Care Physician (PCP)	PCP address	Are you a current patient?
		☐ Yes ☐ No

Race/ethnicity (optional)*
☐ Hispanic/Latino ☐ Asian ☐ White/Caucasian ☐ Black/African American ☐ Other

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☐ Natural/ Adopted child

☐ Stepchild

☐ Other

Family member last name	First name	Middle initial	Social Security number - -
Birth date (month/day/year) / /	Gender ☐ Male ☐ 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? ☐ Yes ☐ No
Race/ethnicity (optional)* ☐ Hispanic/Latino ☐ Asian ☐ White/Caucasian ☐ Black/African American ☐ 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 ☐ Union ☐ Non-Union ☐ Salary ☐ Hourly

Retiree ☐ Early retiree (under 65) ☐ Retiree (65+) ☐ Surviving spouse

Reason ☐ New hire ☐ Open enrollment ☐ QMSCO ☐ Other _____
☐ New group ☐ Re-hire ☐ Loss of coverage (submit proof)

COBRA continuation ☐ 18 months ☐ 29 months ☐ 36 months
☐ Qualifying event date: _____ ☐ COBRA effective date: _____

Coverage (as applicable)

Health ☐ HMO open access ☐ EPO ☐ POS open access ☐ PPO ☐ IND **PPO network:** _____

Dental ☐ Single ☐ Family ☐ High ☐ Low

Vision ☐ Single ☐ Family ☐ High ☐ Low

CEH ☐ HRA ☐ HSA ☐ HBCA ☐ HBC ☐ HBCI

Health option (if applicable) ☐ High ☐ Mid ☐ 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

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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.