

Enrollment Form



How to complete your enrollment form

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 616 464-8550 or 866 464-5257

Section 1: Employee Information	<p>This information is about the person who will be carrying the insurance.</p> <p>*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.</p>
Section 2: Waiver of Coverage (if applicable)	<p>Complete this section if you choose not to accept coverage by Priority Health for you, your spouse or dependents.</p>
Section 3: Dependent Information	<p>This information must be completed if you would like coverage for your spouse and dependents.</p> <p>Reminder: If your dependent is over the age of 19 and is a full-time student, you must also complete SECTION 4 and attach proof of full-time student status.</p> <p>*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.</p>
Section 4: Dependents age 19 and over with full-time student status	<p>Complete this section if your dependent is a full-time student and over the age of 19.</p> <p>Reminder: To help us validate this coverage, be sure to attach proof of student status (acceptable documents to attach are registration or class schedule).</p>
Section 5: Other Insurance Information	<p>Complete this section if you, your spouse, or dependents will have coverage under another health plan or policy including Medicare. This will help us coordinate your benefits with your other insurance coverage.</p> <p>Reminder: Be sure to attach a copy of your other medical insurance coverage ID card.</p>
Section 6: Authorization	<p>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.</p>

Plan type: Standard Enhanced

Plan level: Single Double Single & child(ren) Family

SECTION 1 - EMPLOYEE INFORMATION

Please use only blue or black ink

Employee Last Name First Name MI Social Security Number

Street Address

City State Zip Code Gender MALE FEMALE

Home Phone Work Phone Birth Date Marital Status Single Separated Widowed Married Divorced

e-mail Address Race/Ethnicity (Optional)* White/Caucasian Hispanic/Latino Other Black/African American Asian

Employee's Priority Health Primary Care Provider (PCP) (REQUIRED IF HMO) PCP Code

Are you a current patient? Yes No Employee covered by other insurance? (If yes, complete section 5) Yes No

SECTION 2 - REFUSAL OF COVERAGE (IF APPLICABLE)

Please use only blue or black ink

I hereby certify that I have been offered coverage under the Benefit Plan(s) sponsored by my Employer, and have decided NOT to take advantage of this offer. If I request to add coverage at a later date, I will be subject to the terms and limitations as described in the Summary Plan Description.

COVERAGE REFUSED: Medical Coverage for Myself Medical Coverage for my Eligible Dependents Other _____
 Dental Coverage for Myself Dental Coverage for my Eligible Dependents
 Vision Coverage for Myself Vision Coverage for my Eligible Dependents
 Other _____ Flexible Spending

Employee Signature: _____

Date: _____

SECTION 3 - DEPENDENT INFORMATION

Please use only blue or black ink

If your dependent is over age 19 and a full-time student, you must also complete section 4.

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).

1 Spouse	Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Gender <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	Social Security Number <input type="text"/>	Birth Date <input type="text"/>	e-mail Address <input type="text"/>	
	Primary Care Provider Name (REQUIRED IF HMO/EPO) <input type="text"/>	PCP Code <input type="text"/>	Race/Ethnicity (Optional)* <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Other	
	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2	Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Gender <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	Social Security Number <input type="text"/>	Birth Date <input type="text"/>	e-mail Address <input type="text"/>	
	Primary Care Provider Name (REQUIRED IF HMO/EPO) <input type="text"/>	PCP Code <input type="text"/>	Race/Ethnicity (Optional)* <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Other	
	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3	Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Gender <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	Social Security Number <input type="text"/>	Birth Date <input type="text"/>	e-mail Address <input type="text"/>	
	Primary Care Provider Name (REQUIRED IF HMO/EPO) <input type="text"/>	PCP Code <input type="text"/>	Race/Ethnicity (Optional)* <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Other	
	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4	Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Gender <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	Social Security Number <input type="text"/>	Birth Date <input type="text"/>	e-mail Address <input type="text"/>	
	Primary Care Provider Name (REQUIRED IF HMO/EPO) <input type="text"/>	PCP Code <input type="text"/>	Race/Ethnicity (Optional)* <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Other	
	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Employer Enrollment Form



How to complete your employer section

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

Group Number	List your Priority Health group number to ensure proper benefits and billing.
Sub Group 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.