



ENROLLMENT FORM

SECTION 1 - EMPLOYEE INFORMATION

Employee's Last Name		First Name		Middle Initial	Social Security Number	
Street Address			City		State	Zip Code
Home Phone () -		Work Phone () -		Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		Birth Date / /
Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>				Employee's Priority Health Primary Care Provider (PCP) (REQUIRED)		
Have you seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/ID Code				
PRODUCT HMO <input type="checkbox"/> POS <input type="checkbox"/>				OPTION (If Applicable) High <input type="checkbox"/> Mid <input type="checkbox"/> Low <input type="checkbox"/>		

Please list spouse and/or dependents who will be covered under this policy (if you have more than 4 dependents please complete an additional Enrollment Form.)

1	Spouse/Dependent's Last Name		First Name		Middle Initial	Social Security Number	
	Birth Date / /		Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		Relation to Employee		Priority Health Primary Care Provider (PCP) (REQUIRED)
	Has the dependent seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/ID Code				
2	Dependent's Last Name		First Name		Middle Initial	Social Security Number	
	Birth Date / /		Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		Relation to Employee		Priority Health Primary Care Provider (PCP) (REQUIRED)
	Has the dependent seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/ID Code				
3	Dependent's Last Name		First Name		Middle Initial	Social Security Number	
	Birth Date / /		Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		Relation to Employee		Priority Health Primary Care Provider (PCP) (REQUIRED)
	Has the dependent seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/ID Code				
4	Dependent's Last Name		First Name		Middle Initial	Social Security Number	
	Birth Date / /		Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		Relation to Employee		Priority Health Primary Care Provider (PCP) (REQUIRED)
	Has the dependent seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/ID Code				

SECTION 2 - COORDINATION OF BENEFITS

If you, your spouse, or any dependents are covered by Medicare or any other insurance policy providing medical benefits, please complete this section.

WHERE ARE CLAIMS SENT?	Company Name		Company Address			
POLICY HOLDER INFORMATION	Name of Policyholder		Birth Date / /		Employer	Policy Effective Date / /
	Family Member(s) Covered (1) (2) (3) (4)					
REASON FOR MEDICARE	End Stage Renal Disease <input type="checkbox"/> Disabled <input type="checkbox"/> Over Age 65 <input type="checkbox"/> Over Age 65 and Working <input type="checkbox"/>					Medicare Effective Date / /

SECTION 3 - AUTHORIZATION

I apply 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. I understand that Priority Health cannot process my Enrollment Form on time unless I fill in all the information above, in particular, list a PCP for my enrolled dependents and myself. All of the information I have given above is complete and correct.

Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.

X _____ / /
 Employee Signature Date

For Employer Use Only	Employer			Work Location of Employee		
	Employer Representative Signature					Date / /
	Group Number		Sub Group Number	Class	Date of Hire / /	Effective Date
	PLEASE CHECK ALL APPLICABLE BOXES:	TYPE Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Salary <input type="checkbox"/> Hourly <input type="checkbox"/> Cobra <input type="checkbox"/> Early Retiree (Under 65) <input type="checkbox"/> Retiree (65+) <input type="checkbox"/>				
		LONG TERM DISABILITY <input type="checkbox"/> Date of Disability / /				
REASON	New Hire <input type="checkbox"/> New Group <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of Other Coverage <input type="checkbox"/> Reason: _____					
	COBRA CONTINUATION 18 Month <input type="checkbox"/> 29 Month <input type="checkbox"/> 36 Month <input type="checkbox"/>			Qualifying Event Date / /		Effective Date / /
For Priority Health Use Only	Date Received		Processor	Code	Date Processed	

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