



ENROLLMENT FORM

SECTION 1 - EMPLOYEE INFORMATION

Employee's Last Name		First Name		Middle Initial	Social Security Number	
Street Address			City	County	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)		
Have you seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/Location				
PRODUCT HMO <input type="checkbox"/> POS <input type="checkbox"/> ASO <input type="checkbox"/> ASO-EPO <input type="checkbox"/> ASO-POS <input type="checkbox"/>				OPTION (If Applicable) High <input type="checkbox"/> Low <input type="checkbox"/> Outside the Service Area <input type="checkbox"/>		

SECTION 2 - DEPENDENT INFORMATION (HMO/EPO MUST SELECT PCP)

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	
	Has the dependent seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/Location			
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	
	Has the dependent seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/Location			
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	
	Has the dependent seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/Location			
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	
	Has the dependent seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/Location			

SECTION 3 - 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 4 - AUTHORIZATION

I apply for coverage for each person listed above and agree that we will abide by the Certificate of Coverage or Summary Plan Description. I authorize any person or entity having information regarding our medical care to release that information to Priority Health. Photocopies of this authorization may be used until I revoke the authorization in writing. I agree that no claims will be covered until this application is approved by Priority Health or unless stated in my Summary Plan Description. I understand that my enrollment cannot be processed on a timely basis unless I had listed a PCP for myself and my enrolled dependents. All information stated above is accurate and complete.

X _____ / /
Employee Signature Date

For Employer Use Only	Employee/Company Name			Work Location of Employee		
	Employer/Company Representative Signature					Date / /
	Group Number		Site	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			RETIREE Early Retiree (Under 65) <input type="checkbox"/> Retiree (65+) <input type="checkbox"/>	
		REASON New Hire <input type="checkbox"/> New Group <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/>			Reason: _____	
	COBRA CONTINUATION 18 Month <input type="checkbox"/> 29 Month <input type="checkbox"/> 36 Month <input type="checkbox"/>			Qualifying Event Date / /		
				Event Date / /		
For Priority Health Use Only	Date Received / /		Contract Number	Processor	Code	Date Processed / /

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