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

continued >

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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**

Employee Name: _____ SSN: _____

5 ☐ 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			
	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			
6 ☐ 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			
	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			
7 ☐ 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			
	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			
8 ☐ 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			
	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			
9 ☐ 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			
	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			

Employee Name: _____ SSN: _____

10 ☐ 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			
	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			
11 ☐ 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			
	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			
12 ☐ 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			
	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			
13 ☐ 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			
	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			
14 ☐ 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			
	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			

Employee Name: _____ SSN: _____

15 ☐ 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			
	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			
16 ☐ 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			
	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			
17 ☐ 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			
	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			
18 ☐ 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			
	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			
19 ☐ 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			
	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			