Enrollment form instructions

Priority Health

Priority Health · MS 2275
1231 E. Beltline NE, Grand Rapids, MI 49525
Fax to: 616.942.5242

Employees

Thank you for choosing Priority Health. Please complete this form for yourself and any dependents you wish to cover. Please note this form should only be used if you are newly enrolling to the plan.

- 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 your employer, 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.
Dependent 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 5, please complete an additional enrollment form. *Note: Please indicate if a dependent lives outside of the Priority Health Michigan service area to ensure appropriate coverage. Go to priorityhealth.com and search for "service area" to see a map or call us for more information.*
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 the Summary Plan Description that applies to your coverage.

Social Security number is required to comply with federal reporting requirements.

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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Employers

Thank you for choosing Priority Health for your employees. Please note this form should only be used for new enrollments on the plan. 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, etc.).
Class	List the appropriate class to indicate active, retired or specific group location (CA01, CA02, CC01, CE01, etc.).
Your company name, email and contact phone number	Complete your company name, phone number and email 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, Health Option).
Company representative signature	Your signature is needed to verify the employee's eligibility for coverage.

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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

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

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

Are you or any of your dependents covered under another insurance plan? If yes, please provide the following information:	Other carrier information	Effective date of coverage

Primary Care Provider (doctor) last name	Doctor first name	Are you a current patient? ☐ Yes ☐ No

Doctor street address	City	State	ZIP code

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 your coverage.

Employee signature X _____	Today's date / /

To be completed by employer (form cannot be processed without this information)

Original date of hire	**For re-hire employee** – Date of re-hire / /	Eligibility date / /	Effective date / /

Group number	Subgroup number	Class

Company name

Company phone ( )	Email 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 ☐ QMCSO (proof required) ☐ Change of employment status ☐ New group ☐ Re-hire ☐ Move into service area ☐ Loss of coverage ☐ Birth ☐ Marriage ☐ Adoption (proof required) ☐ Other _____

COBRA continuation ☐ 18 months ☐ 29 months (proof required) ☐ 36 months ☐ Qualifying event date: _____ ☐ COBRA effective date: _____

Coverage (if applicable)

Health Plan ☐ HMO open access ☐ EPO ☐ POS open access ☐ PPO ☐ Indemnity

PPO network

Health option (if applicable) ☐ High ☐ Mid ☐ Low

☐ HSA ☐ HRA ☐ PriorityWell Choice Benefits

Dental ☐ Single ☐ Double ☐ Family

Vision ☐ Single ☐ Double ☐ Family

Employer signature **X** _____	**Today's date** **/ /**

Dependent information (Your spouse, domestic partner and eligible children you wish to enroll)

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☐ Spouse
☐ Domestic partner
☐ Child
☐ Stepchild
☐ Other:

If applicable

☐ Dental
☐ Vision

Dependent last name	First name	Middle initial	Social Security number - -
Gender ☐ Male ☐ Female	Birth date (month/day/year) / /	Email address	Race/Ethnicity (optional)
Dependent street address			
City	State	ZIP code	Is this address outside of the Priority Health service area? ☐ Yes ☐ No
Covered under another insurance plan? ☐ Yes ☐ No If different from above, please provide other carrier information and effective date.			
Primary Care Provider (doctor) last name	Doctor first name	Are you a current patient? ☐ Yes ☐ No	
Doctor street address	City	State	ZIP code

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☐ Child
☐ Stepchild
☐ Other:

If applicable

☐ Dental
☐ Vision

Dependent last name	First name	Middle initial	Social Security number - -
Gender ☐ Male ☐ Female	Birth date (month/day/year) / /	Email address (for dependents 18 and older)*	Race/Ethnicity (optional)
Dependent street address			
City	State	ZIP code	Is this address outside of the Priority Health service area? ☐ Yes ☐ No
Covered under another insurance plan? ☐ Yes ☐ No If different from above, please provide other carrier information and effective date			
Primary Care Provider (doctor) last name	Doctor first name	Are you a current patient? ☐ Yes ☐ No	
Doctor street address	City	State	ZIP code

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☐ Child
☐ Stepchild
☐ Other:

If applicable

☐ Dental
☐ Vision

Dependent last name	First name	Middle initial	Social Security number - -
Gender ☐ Male ☐ Female	Birth date (month/day/year) / /	Email address (for dependents 18 and older)*	Race/Ethnicity (optional)
Dependent street address			
City	State	ZIP code	Is this address outside of the Priority Health service area? ☐ Yes ☐ No
Covered under another insurance plan? ☐ Yes ☐ No If different from above, please provide other carrier information and effective date			
Primary Care Provider (doctor) last name	Doctor first name	Are you a current patient? ☐ Yes ☐ No	
Doctor street address	City	State	ZIP code

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☐ Child
☐ Stepchild
☐ Other:

If applicable

☐ Dental
☐ Vision

Dependent last name	First name	Middle initial	Social Security number - -
Gender ☐ Male ☐ Female	Birth date (month/day/year) / /	Email address (for dependents 18 and older)*	Race/Ethnicity (optional)
Dependent street address			
City	State	ZIP code	Is this address outside of the Priority Health service area? ☐ Yes ☐ No
Covered under another insurance plan? ☐ Yes ☐ No If different from above, please provide other carrier information and effective date			
Primary Care Provider (doctor) last name	Doctor first name	Are you a current patient? ☐ Yes ☐ No	
Doctor street address	City	State	ZIP code

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☐ Child
☐ Stepchild
☐ Other:

If applicable

☐ Dental
☐ Vision

Dependent last name	First name	Middle initial	Social Security number - -
Gender ☐ Male ☐ Female	Birth date (month/day/year) / /	Email address (for dependents 18 and older)*	Race/Ethnicity (optional)
Dependent street address			
City	State	ZIP code	Is this address outside of the Priority Health service area? ☐ Yes ☐ No
Covered under another insurance plan? ☐ Yes ☐ No If different from above, please provide other carrier information and effective date			
Primary Care Provider (doctor) last name	Doctor first name	Are you a current patient? ☐ Yes ☐ No	
Doctor street address	City	State	ZIP code