HIGHMARK.

ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY IN BLUE OR BLACK INK. DO NOT USE PENCIL OR HIGHLIGHTER

☒ ENROLLING (Complete sections I, II, IV, and V)

☐ WAIVING (Complete sections I and III)

I. EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date: 05/04/23
Employer/Group Name: JW - Marriott Patriot - Health Center
Group Number: 37804991
Payroll Location:
First Name: Dennis
MI: H.
Last Name: Larsonel
Social Security Number (If no SSN, write N/A): 417865749
Address: 1406 Greenpark Road, Allyson CIR
City: OR Fallon
State: PA
Zip: 166210
County: Monroe
Home/Cell Phone: (760) 934-9670
Marital Status (Please select one): ☒ Single/Widowed ☐ Married ☐ Divorced
Employment Status: ☒ Active Employee ☐ Retired Employee
☐ COBRA Continuation Start Date ________
(Please attach a copy of your COBRA Notice or HIPAA Certificate to support eligibility)
Full Time Hire Date or Rehire (Month/Day/Year): 16 / 04 / 2023
Hours Worked Per Week: 37.5
Job Title: Laboratory Manager
Gender: ☒ Male ☐ Female
Date of Birth (Month/Day/Year): 05 / 08 / 2001
Age: 23
Product Selection(s): ☐ Medical Product Name: ________ ☒ Vision ☐ Dental
Full Name of Physician of Record (POR) Group Practice: Daniel C. Hardman
POR Number from Provider Directory: N/A
Are you an Established Patient? ☒ Yes ☐ No

II. DEPENDENT INFORMATION (If enrolling more than four dependents, please attach a separate sheet)

First Name: N/A
MI:
Last Name:
Relationship to You? ☐ Spouse ☐ Domestic Partner*
Social Security Number (If no SSN, write N/A):
Gender: ☐ Male ☐ Female
Date of Birth (Month/Day/Year): / /
Age:
Product Selection(s): ☐ Medical ☐ Vision ☐ Dental
Full Name of Physician of Record (POR) Group Practice:
POR Number from Provider Directory:
Is Spouse/DP an Established Patient? ☐ Yes ☐ No

Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage certificate.

*If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.

First Name: Hobart
MI: P
Last Name: Larsonel
Relationship to You? ☐ Child ☑ Step child ☐ Adopted* ☐ Other*
Social Security Number (If no SSN, write N/A): 775785745
Gender: ☑ Male ☐ Female
Date of Birth (Month/Day/Year): 01 / 14 / 1998
Age: 25
Product Selection(s): ☐ Medical ☒ Vision ☐ Dental
Dependent Status If Age 26 or Older: ☐ Disabled ☐ Act 4**
Full Name of Physician of Record (POR) Group Practice:
POR Number from Provider Directory:
Is Child an Established Patient? ☐ Yes ☒ No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.