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: 4/1/2024
Employer/Group Name: UTC Credit Global
Group Number: 1639736
Payroll Location: Grover, OH

First Name: Bretny
MI: C
Last Name: Kleen
Social Security Number (If no SSN, write N/A): 140-73-2711

Address: 6246 Shakespeartown Rd.
City: Fresno
State: OH
Zip: 917410
County: York
Home/Cell Phone: (765) 513-9902

Marital Status (Please check one):
☐ Single/Widowed ☒ Married ☐ Divorced

Enrollment Status:
☒ Active Employee ☐ COBRA Continuant Start Date ___/___/___
☐ Retired Employee ☐ HIPAA Life Event
(Please attach a copy of COBRA Election Notice or HIPAA Certificate to support eligibility)

Full-Time Hire (or Rehire) Date (Month/Day/Year): May 18 2022
Hours Worked Per Week: 40
Job Title: Chief Executive officer

Gender: ☐ Male ☐ Female
Date of Birth (Month/Day/Year): July 18 1971
Age: 52
Product Selection(s): ☒ Medical Product Name: Gold Plan ☒ Vision ☒ Dental

Full Name of Physician of Record (POR) Group Practice: Dr Debby Tu
POR Number from Provider Directory:
Are you an Established Patient? ☒ Yes ☐ No

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

SPOUSE/DOMESTIC PARTNER

First Name: Kim
MI: J
Last Name: Yuncheol
Relationship to You? ☒ Spouse ☐ Domestic Partner*
Social Security Number (If no SSN, write N/A): 840-13-1846
Gender: ☒ Male ☐ Female
Date of Birth (Month/Day/Year): 08/21/1970
Age: 53
Product Selection(s): ☒ Medical ☒ Vision ☒ Dental
Full Name of Physician of Record (POR) Group Practice: Dr Debby Tu
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.

DEPENDENT CHILD

First Name:
MI:
Last Name:
Relationship to You? ☐ Child ☐ Step-child ☐ Adopted* ☐ Other*
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
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.