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	Employer/Group Name	Group Number	Payroll Location
6/1/2024	Manhattan Constructions Inc	1849609	Berwick

First Name	MI	Last Name	Social Security Number (If no SS#, write N/A)
WENDY	E	Augustin	457-050-6081

Address: 8150 Harper Blvd 7th Street 711 Dr

City	State	Zip	County	Home/Cell Phone
Erie	Oh	186655	Mill Creek	(819) 837-5185

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

Enrollment Status
☐ Active Employee ☐ COBRA Continuant Start Date ___/___/___
☒ Rehired 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)	Hours Worked Per Week	Job Title
11/23/2022	38	Construction Director

Gender	Date of Birth (Month/Day/Year)	Age	Product Selection(s)
☐ Male ☒ Female	02/19/59	64	☐ Medical Product Name: Premium ☐ Vision ☐ Dental

Black Diamond $8000

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
	04216	☒ Yes ☐ No

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

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You?
Ronald	H	Augustin	☐ Spouse ☒ Domestic Partner†

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
238-715-408	☒ Male ☐ Female	07/29/56	67

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?
DR. Mitch Bassmo	086233	☑ 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
Lily	M	Lester	☒ Step-child ☐ Adopted* ☐ Other*

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
717 61 8894	☐ Male ☒ Female	1/11/1998	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?
Milton Children Hospital		☒ 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.