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
Jan 1, 2024	Syndicate Legal Aid	32081881	Reading

First Name	MI	Last Name	Social Security Number (If no SSN, write N/A)
William	E	Anglyson	457-30-6881

Address: 650 LEGACY FARM BLVD

City	State	Zip	County	Home/Cell Phone
READING	SD	17606	BERKS	765823-9674

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

Employment 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)	Hours Worked Per Week	Job Title
/ 09 / 01 2013	40 +	Legal Consultant

Gender	Date of Birth (Month/Day/Year)	Age	Product Selection(s)
☐ Male ☑ Female	11 / 19 / 1970	53	☑ Medical Product Name: Product Savings ☐ Vision ☑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
TNT HEALTH		☑ 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?
LORI ~~NICHOLSON~~	E	NICHOLSON	☑ Spouse ☐ Domestic Partner†

Social Security Number (If no SSN, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
980-51-4189	☑ Male ☐ Female	06 / 15 / 1990	33

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?
FAMILY MEDHEALTH		☐ 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?
JONNA	P	NICHOLSON	☑ Child ☐ Step-child ☐ Adopted* ☐ Other*

Social Security Number (If no SSN, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
457-30-6885	☐ Male ☑ Female	12 / 18 / 2005	18

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?
TNT HEALTH PEDIATRICS		☑ 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.