



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, III, and IV)
- ☐ WAIVING
(Complete sections I and II)

I. EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrolling and waiving)

Effective Date 1/08/2024	Employer/Group Name Heart Foundation Inc.	Group Number 44168015	Payroll Location Dauphin
First Name Samarra	MI H	Last Name D'Souza	Social Security Number (If no SSN, write N/A) 815-66-1302
Address 135 Hershey Apts; Bigben Square			
City Pittsburgh	State PA	Zip 15506	County Erie
Home/Cell Phone 899-891-8626			
Marital Status (Please check one): <input type="checkbox"/> Single/Widowed <input checked="" type="checkbox"/> Married		Enrollment Status <input checked="" type="checkbox"/> Active Employee <input type="checkbox"/> Rehired Employee <input type="checkbox"/> COBRA Continuant Start Date <input type="checkbox"/> 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) 11/11/2018	Hours Worked Per Week 42+	Job Title Health Care Analyst	
Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Date of Birth (Month/Day/Year) 12/31/77	Age 46	Product Selection(s) <input checked="" type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental
Full Name of Physician of Record (POR) Group Practice DR. MUNHALL PERCY		POR Number from Provider Directory 001189	Are you an Established Patient? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

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

SPOUSE/DOMESTIC PARTNER

First Name Franklin	MI L	Last Name D'Souza	Relationship to You? <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner
Social Security Number (If no SSN, write N/A) 803-19-9728		Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) 04/14/1976
Product Selection(s): <input checked="" type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental		Age 47	
Full Name of Physician of Record (POR) Group Practice Dr. Lamina Nanci		POR Number from Provider Directory 113203	Is Spouse/DP an Established Patient? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted <input type="checkbox"/> Other
Social Security Number (If no SSN, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year)
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental		Dependent Status if Age 26 or Older <input type="checkbox"/> Disabled <input type="checkbox"/> Act 4*	
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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.