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
9-1-2023	KRG Management, LLC	1902531	ALLEGHENY

First Name	MI	Last Name	Social Security Number (If no SS#, write N/A)
Roberta		Boyle	496-516-1216

Address: APT 1218 Amanda St., Crescent Villa Gardens

City	State	Zip	County	Home/Cell Phone
PgH		105146	ALLEGHENY	9241655581

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
1/24/2024	60	Community Planning Manager

Gender	Date of Birth (Month/Day/Year)	Age	Product Selection(s)
☐ Male ☒ Female	8/05/88	35	☐ Medical Product Name: ___ ☒ Vision ☐ Dental

Full Name of Physician of Record (POR) Group Practice	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	MI	Last Name	Relationship to You?
Robert	K	Lannister	☒ Spouse ☐ Domestic Partner†

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
519-63-4132	☒ Male ☐ Female	10/11/2012	

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?
Thomas Speciality	(873-81)	☐ 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
Arya	G	Boyle	☒ Step-child ☐ Adopted* ☐ Other*

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
489-31-6296	☐ Male ☒ Female	06/27/2022	2

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.