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)

* OPEN ENROLLMENT 2024

I EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date: 06/05/2023 | Employer/Group Name: Universal Parcel Service | Group Number: 17391992 | Payroll Location: Tampa

First Name: Chalsey | MI: B | Last Name: Lockhart | Social Security Number (If no SS#, write N/A): 980-51-4190

Address: 47 Tampa Ave

City: Tampa | State: MN | Zip: 33615 | County: Columbia | Home/Cell Phone: 765-239-9657

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

Enrollment Status: ☐ Active Employee ☒ COBRA Continuant Start Date: 06/05/2023 ☐ 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): 02/08/2022 | Hours Worked Per Week: 40 | Job Title: Assistant Supervisor

Gender: ☒ Male ☐ Female | Date of Birth (Month/Day/Year): 04/12/2006 | Age: 17 | Product Selection(s): ☐ 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: Rebekah | MI: C | Last Name: Lockhart | Relationship to You? ☒ Spouse ☐ Domestic Partner†

Social Security Number (If no SS#, write N/A): 980-91-3731 | Gender: ☐ Male ☒ Female | Date of Birth (Month/Day/Year): 05/14/2003 | Age: 20

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? ☐ 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 SS#, 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.