HIGHMARK

ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY
IN BLUE OR BLACK INK.
DO NOT USE PENCIL OR HIGHLIGHTER.

Open enrollment

☒ ENROLLING

☐ WAIVING

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

Effective Date: 1/14/2023

Employer/Group Name: Apollo Health Inc

Group Number: 32018470

Payroll Location:

First Name: Courtney | MI: D | Last Name: Stuart

Social Security Number (if no SS#, write N/A): 2561-73-7644

Address: 1058 SE. Willows St

City: W-B Scranton | State: PA | Zip: 174994 | County: Zerne New

Home/Cell Phone: (540) - 762 - 9013

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

Enrollment 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): 06 / 02 / 2028

Hours Worked Per Week: 40

Job Title: Ward Incharge

Gender: ☐ Male ☒ Female

Date of Birth (Month/Day/Year): 06 / 26 / 1988

Age: 35

Product Selection(s): ☐ Medical Product Name: ☐ Vision ☐ Dental

Full Name of Physician of Record (POR) Group Practice: Dr. Wolowitz (Coltonz)

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)

First Name: Colton | MI: C | Last Name: Stuart

Social Security Number (if no SS#, write N/A): 173 73 5248

Relationship to You? ☐ Spouse ☒ Domestic Partner*

Gender: ☒ Male ☐ Female

Date of Birth (Month/Day/Year): 10 / 02 / 1994

Age: 29

Product Selection(s): ☐ Medical ☐ Vision ☐ Dental

Full Name of Physician of Record (POR) Group Practice: Dr. Wolowitz

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.

First Name: Taylor | MI: R | Last Name: Norton

Social Security Number (if no SS#, write N/A): 757 - 58 - 9613

Relationship to You? ☐ Child ☐ Step-child ☒ Adopted* ☐ Other*

Gender: ☒ Male ☐ Female

Date of Birth (Month/Day/Year): 11 / 17 / 2021

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.