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 VI)

☐ WAIVING (Complete sections I and III)

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

Effective Date: 04/3/23 | Employer/Group Name: Archin Meche's Law LLC | Group Number: 19911738 | Payroll Location:

First Name: Alexei | MI: | Last Name: Smirnov | Social Security Number (If no SS#, write N/A): 119-41-3137

Address: 412 Park Ave E

City: Princeton | State: VT | Zip: 61357 | County: Ridge Town | Home/Cell Phone: 239-765-7896

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): / 10/23/2001 | Hours Worked Per Week: 40 | Job Title:

Gender: ☑ Male ☐ Female | Date of Birth (Month/Day/Year): 02/16/1958 | Age: 65 | Product Selection(s): ☐ Medical Product Name: ☑ Vision ☐ Dental

Full Name of Physician of Record (POR) Group Practice: Princeton General Hospital | 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: Sofiya | MI: | Last Name: Smirnova | Relationship to You? ☑ Spouse ☐ Domestic Partner†

Social Security Number (If no SS#, write N/A): 119-41-3138 | Gender: ☐ Male ☑ Female | Date of Birth (Month/Day/Year): 04/18/1960 | Age: 63

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

Full Name of Physician of Record (POR) Group Practice: Princeton General Hospital | 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: Teresa | MI: | Last Name: Passalacqua | Relationship to You? ☑ Child ☐ Step-child ☐ Adopted* ☐ Other*

Social Security Number (If no SS#, write N/A): 119-41-3139 | Gender: ☐ Male ☑ Female | Date of Birth (Month/Day/Year): 10/18/2000 | Age: 23

Dependent Status if Age 26 or Older: ☐ Disabled ☐ Act 4**

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

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.