HIGHMARK.

ENROLLMENT/WAIVER FORM

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

☒ ENROLLING
(Complete sections A, B and C)

☐ WAIVING
(Complete sections A and B)

A. EMPLOYER/CONTRACTHOLDER INFORMATION (To be completed by contract holder and employer)

Effective Date	Employer/Group Name	Group Number	Payroll Location
06/01/2022	Razpzoo Neft Limited	0124529	Carbon

First Name	MI	Last Name	Social Security Number (If no SS#, write N/A)
Cassidy	J	Walker	879-07-1464

Address
5841 S Maryland Ave, Washington St.

City	State	Zip	County	Home/Cell Phone
Chicago	OH	60637	Jonesboro	(293)-765-657

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)	Hours Worked Per Week	Job Title
02 26 2016	50	Assistant Constn. Engineer

Gender	Date of Birth (Month/Day/Year)	Age	Product Selection(s)		
☐ Male ☒ Female	04 / 03 / 1983	40	☒ Medical Product Name: Paramun Plan1000	☐ Vision	☒ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
Dr. Alex Ross		☒ Yes ☐ No

B. SPOUSE/DOMESTIC PARTNER INFORMATION (To be completed by contract holder)

First Name	MI	Last Name	Relationship to You?
TERESA		PASSALACQUA	☒ Spouse ☐ Domestic Partner*

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
114-91-3737	☐ Male ☒ Female	09/18/1985	37

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?
Dr. Smith		☒ 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.

C. DEPENDENT INFORMATION (To be completed by contract holder)

First Name	MI	Last Name	Relationship to You?
			☐ Child ☐ Step-child ☐ Adopted* ☐ Other*

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
	☐ Male ☐ Female	/ /	

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.