HIGHMARK.

ENROLLMENT/WAIVER FORM OPEN ENROLLMENT

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: 6/1/2024
Employer/Group Name: MANHATTAN CONSTRUCTIONS INC
Group Number: 1849659
Payroll Location: Berwick
First Name: Ronald
MI: H
Last Name: Augusta
Social Security Number (If no SS#, write N/A): 457-50-6681
Address: 1058 Winterland Blvd. Ocean Dune
County: Millcreek
Home/Cell Phone: (819) 837-5185
City: W-B Scranton
State: PA
Zip: 174994
Enrollment Status: ☑ Active Employee ☐ Rehired Employee ☐ COBRA Continuant Start Date / / ☐ HIPAA Life Event
(Please attach a copy of COBRA Election Notice or HIPAA Certificate to support eligibility.)
Marital Status (Please check one): ☐ Single/Widowed ☐ Married ☑ Divorced
Full-Time Hire (or Rehire) Date (Month/Day/Year): 09/15/23 10/15/2023
Hours Worked Per Week: 38
Job Title: Construction Director
Gender: ☑ Male ☐ Female
Date of Birth (Month/Day/Year): 02/19/59
Age: 64
Product Selection(s): ☑ Medical Product Name: BLACK DIAMOND * 8000 PREMIUM ☑ Vision ☑ Dental
Full Name of Physician of Record (POR) Group Practice: Dr. Wolowitz (Colton2)
POR Number from Provider Directory: 086232
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: WENDY
MI: E
Last Name: Augusta
Relationship to You? ☐ Spouse ☒ Domestic Partner†
Social Security Number (If no SS#, write N/A): 238-715-408
Gender: ☐ Male ☒ Female
Date of Birth (Month/Day/Year): 07/29/56
Age: 67
Product Selection(s): ☒ Medical ☒ Vision ☒ Dental
Full Name of Physician of Record (POR) Group Practice: Rainbow Hospital (Dr. Bassmo)
POR Number from Provider Directory: 04216
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: Lily
MI: M
Last Name: Lesteer
Relationship to You? ☐ Child ☒ Step-child ☐ Adopted* ☐ Other*
Social Security Number (If no SS#, write N/A): 879-071465
Gender: ☐ Male ☒ Female
Date of Birth (Month/Day/Year): 1/11/1998
Age: 25
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: MILTON CHILDREN HOSPITAL
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.

ENR-129 (RI)