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)

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

Effective Date	Employer/Group Name	Group Number	Payroll Location
01/03/2023	United Health Group		Wyalusing

First Name	MI	Last Name	Social Security Number (If no SS#, write N/A)
Michael	C	Kassidy	179-74-4261

Address: 200 Winterland Blvd, Ocean Drive

City	State	Zip	County	Home/Cell Phone
Wyalusing	TP	188229	Bradford	702 04 7162

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)	Hours Worked Per Week	Job Title
10 / 31 / 2024	60	Clinician

Gender	Date of Birth (Month/Day/Year)	Age	Product Selection(s)
☑ Male ☐ Female	06 / 11 / 1990	34	☑ Medical Product Name: Affordable $50000 ☑ 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	MI	Last Name	Relationship to You?
Bagsson			☐ Spouse ☐ Domestic Partner†

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

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?
Eric	R	Walker	☐ Child ☐ Step-child ☒ Adopted* ☐ Other*

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
879-071465	☒ Male ☐ Female	08 / 19 / 2006	17

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?
Rainbow Hospital		☒ 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.