HIGHMARK

ENROLLMENT/WAIVER FORM

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

X VISION ENROLLING (Complete sections I, II, IV, and V)

☐ WAIVING (Complete sections I and III)

I. EMPLOYEE/CONTRACTHOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date: 3/1/24
Employer/Group Name: Starlit Hallmark
Group Number: 0124526
Payroll Location:
First Name: Thomas
MI: R
Last Name: Gerrard
Social Security Number (Required, Hints N/A): 574 98 8324
Address: 15125
City: Summit Township
State: PA
Zip: 16630
County: Monroe
Home/Cell Phone: 578-239-1802
Marital Status: Please Declare
☐ Single/Widowed ☒ Married ☐ Divorced
Enrollment Status
☒ Active Employee ☐ COBRA Continuant Start Date
☐ Retired Employee ☐ OBRA Effective Date
Please attach a copy of COBRA election Notice or HIPAA Certificate to support eligibility
Job Title: Dance Coordinator
Full-Time Hire (or Rehire) Date (Month/Day/Year): 04/08/2017
Normal Weekly Hours: 40
Gender: ☒ Male ☐ Female
Date of Birth (Month/Day/Year): 03/04/1997
Age: 32
Product Selection(s): ☐ Medical Product Name: ☐ 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 OR DOMESTIC PARTNER

First Name: Sheila
MI: L
Last Name: Gerrard
Relationship to You? ☒ Spouse ☐ Domestic Partner
Social Security Number (Required, Hints N/A): 527 32 5956
Gender: ☐ Male ☒ Female
Date of Birth (Month/Day/Year): 12/08/1994
Age: 29
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 prior 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: Karla
MI: T
Last Name: Gerrard
Relationship to You? ☒ Child ☐ Stepchild ☐ Foster Child ☐ Other
Social Security Number (If no SS#, write N/A): 186 32 7115
Gender: ☐ Male ☒ Female
Date of Birth (Month/Day/Year): 02/10/2001
Age: 23
Product Selection(s): ☐ Medical ☒ Vision ☐ Dental
Dependent Status if Age 26 or Older: ☐ Disabled ☐ Active*
Full Name of Physician of Record (POR) Group Practice:
POR Number from Provider Directory:
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.