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
08/02/2023	Berkshire Hathaway LLC	37287192	3728-2023

First Name	MI	Last Name	Social Security Number (If no SS#, write N/A)
Aubrey	K	Kirbarth	757-79-5750

Address: 4124 PARK BELMONTE

City	State	Zip	County	Home/Cell Phone
Calabasas	CA	91304	Yorkshire	765-239-9688

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
08/23/2014	40	Trading Consultant

Gender	Date of Birth (Month/Day/Year)	Age	Product Selection(s)
☐ Male ☑ Female	06/26/1962	61	☐ Medical Product Name: ☐ Vision ☑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
Dr Sonam Patel Hospital		☐ 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?
			☐ 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?
Alexer		Kirbarth	☑ Child ☐ Step-child ☐ Adopted* ☐ Other*

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
757-79-5753	☑ Male ☐ Female	12/18/1992	31

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.