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: 1-9-24
Employer/Group Name: Raymond Dentistry
Group Number: 28108196
Payroll Location:

First Name: MCKENNA
MI: S
Last Name: FITTO
Social Security Number (if no SSN, write N/A): 924-74-2390

Address: 260 W Glenfield ave

City: YOUNG PHOENIX
State: DE
Zip: 445021
County: Milwaukee
Home/Cell Phone: 765 239-0652

Marital Status (Please check one): ☐ Single/Widowed ☐ Married ☒ Divorced

Enrollment Status: ☐ Active Employee ☐ Retired Employee ☐ COBRA Continuant Start Date ___/___/___ ☐ HIPAA Life Event

(Please attach a copy of COBRA Election Notice or HIPAA Certificate to support eligibility)

Full Time Hire (or Retired) Date (Month/Day/Year): 01 / 2 / 2024
Hours Worked Per Week: 40
Job Title: Office Supretendent

Gender: ☐ Male ☒ Female
Date of Birth (Month/Day/Year): 5 / 14 / 72
Age: 51
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/DOMESTIC PARTNER

First Name: LISA
MI: J
Last Name: FITTO
Relationship to You? ☒ Spouse ☐ Domestic Partner*

Social Security Number (if no SSN, write N/A): 990-34-0862
Gender: ☐ Male ☒ Female
Date of Birth (Month/Day/Year): 02 / 19 / 76
Age: 48

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.

CHILD

First Name: N/A
MI:
Last Name:
Relationship to You? ☐ Child ☐ Step child ☐ Adopted* ☐ Other**

Social Security Number (if no SSN, write N/A):
Gender: ☐ Male ☐ Female
Date of Birth (Month/Day/Year): / /
Age:

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.