HIGHMARK ENROLLMENT/WAIVER FORM

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

ENROLLING

WAIVING

1. EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed by both employee and spouse)

Effective Date: 11/1/24
Employer/Group Name: The Donald's Group
Group Number: 18550607G
Payroll Location:

First Name: Christian | MI: A | Last Name: Keener
Social Security Number (If no SSN, write N/A): 880-13-8457

Address: 1050 South Pole Nentrey Rd
City: Hamburg | State: PA | Zip: 19541 | County: Luzerne
Home/Cell Phone: 484-239-9660

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): 09/25/2023
Hours Worked Per Week: 40
Job Title: Production Manager

Gender: ☒ Male ☐ Female
Date of Birth (Month/Day/Year): 12/24/1986
Age:
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

2. DEPENDENT INFORMATION (If enrolling dependents, complete one section for each dependent.)

First Name | MI | Last Name
Social Security Number (If no SSN, write N/A)
Relationship to You? ☐ Spouse ☐ Domestic Partner*
Gender: ☐ Male ☐ Female
Date of Birth (Month/Day/Year): ___/___/___ Age:
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.

First Name | MI | Last Name
Social Security Number (If no SSN, write N/A)
Relationship to You? ☐ Child ☐ Step-child ☐ Adopted* ☐ Other
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.