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: 5/1/2024
Employer/Group Name: The Home Depot Central of PA
Group Number: 38081295
Payroll Location:

First Name: GREGORY
MI: A
Last Name: BUCESANAN
Social Security Number (If no SSN, write N/A): 199-67-2197

Address: 601 CIRCA PEARSON
City: CALAMAZOO
State: PA
Zip: 14403
County: CAMBRIDGE
Home/Cell Phone: 848 006 9171

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

Enrollment Status:
☑ Active Employee ☐ COBRA Continuant Start Date: / /
☐ Retired 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): 11/14/2023
Hours Worked Per Week: 40
Job Title: Education Training Assistant

Gender: ☐ Male ☑ Female
Date of Birth (Month/Day/Year): 12/13/1955
Age: 68
Product Selection(s): ☐ Medical Product Name: Golden Plan 8000 ☑ Vision ☑ Dental

Full Name of Physician of Record (POR) Group Practice: MEDFORD
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: CHRISTINE
MI: M
Last Name: PAULSON
Relationship to You? ☐ Spouse ☑ Domestic Partner*
Social Security Number (If no SSN, write N/A): 621 71 1844
Gender: ☑ Female ☐ Male
Date of Birth (Month/Day/Year): 02/11/1956
Age: 67
Product Selection(s): ☑ Medical ☑ Vision ☑ Dental
Full Name of Physician of Record (POR) Group Practice: MEDFORD
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? ☐ 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.