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
1/08/2024	Heart Foundation Inc.	44168015	Dauphin

First Name	MI	Last Name	Social Security Number (If no SS#, write N/A)
Samairra ~~[illegible]~~	H	D'Souza	815-66-1302

Address: 135 Horsley Apts; Bigben Square

City	State	Zip	County	Home/Cell Phone
Pittsburgh	PA	18506	Erie	899-891-8626

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

Enrollment Status
☒ Active Employee ☐ COBRA Continuant Start Date [illegible]
☐ 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
11 / 11 / 2018	42+	Health Care Analyst

Gender	Date of Birth (Month/Day/Year)	Age	Product Selection(s)
☐ Male ☒ Female	12 / 31 / 77	46	☒ Medical Product Name: Platinum + $10,000 ☐ Vision ☐ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
DR. MUNHALL PERCY	001189	☐ 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?
Franklin	Lo	D'Souza	☒ Spouse ☐ Domestic Partner†

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
803-19-9728	☒ Male ☐ Female	04 / 14 / 1976 ~~2024~~	47

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?
Dr. Lamina Nanci	113203	☒ 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.

X

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You?
			☐ Child ☐ Step-child ☐ Adopted* ☐ Other*

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age
	☐ Male ☐ Female	/ /	

Product Selection(s):	Dependent Status if Age 26 or Older
☐ Medical ☐ Vision ☐ Dental	☐ 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.